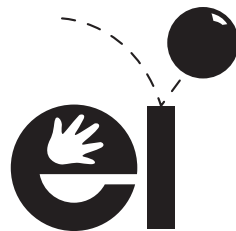


OPERATIONAL STANDARDS

for

RHODE ISLAND EARLY INTERVENTION



early intervention

supporting families and child development

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I. INTRODUCTION

The Rhode Island Department of Health (HEALTH) was designated the lead agency for Part C (formerly known as Part H) of the Individuals with Disabilities Education Act (IDEA) on July 1, 1991. These Operational Standards are based on 34 CFR Part 303, EI Program for Infants and Toddlers with Disabilities, Rhode Island General Laws 23-13-22, and Rhode Island Certification Standards for Early Intervention (EI) issued August 2000. They have been written to give families and providers a common understanding of what the expectations are for EI in Rhode Island.

Rhode Island's EI System encompasses seven local programs, including hospital and community agencies which have been certified as EI providers by HEALTH (see Appendix A), as well as specialty service providers and allied services. The purpose of the EI System is support families' capacity to enhance the growth and development of children birth to 36 months who have developmental challenges. Eligible children may have certain diagnosed conditions, delays in their development, or be experiencing circumstances, which are likely to result in significant developmental problems, particularly without intervention.

The foundation of EI is the collaboration between families and professionals, using a family-centered approach. EI strives to provide comprehensive, community-based, culturally sensitive services designed to meet the developmental challenges of eligible children and families' needs as related to enhancing eligible children's development. Families, together with EI professionals, determine developmental goals or next steps for eligible children. These goals, and the services needed to support obtaining these goals, are written in an Individualized Family Service Plan (IFSP).

The delivery of service to an eligible child is a joint process in which family members are full partners; thus the education of family members is a primary goal of all EI activities. This process is coordinated by certified EI providers. To the maximum extent possible, services are provided in home and community locations so that naturally occurring learning opportunities may be maximized. For a list of definitions used in this document, please refer to Appendix B.

II. FAMILY PARTICIPATION

Family centered practice is an essential element and core value of all successful EI services; Families' priorities and strengths are at the center of EI and families are equal partners in the design and delivery of services.

Eligible children and families must have equal access to comprehensive EI programming, regardless of geographic location. EI programming must be made available to all eligible children, regardless of gender, race, ethnicity, religious beliefs, cultural orientation, economic status, and educational, medical diagnosis or disabling condition.

Each EI provider must utilize evaluation and assessment procedures that are responsive to the unique demographic, cultural, racial, and ethnic characteristics of families served. EI staff and parent consultants adopt, adjust, and monitor best family centered practice in an ongoing process to improve the quality of the EI program.

This means that:

- Family centered home- and community-based services and supports, which are accessible, comprehensive, and culturally competent must be provided.
- Families of eligible children actively participate in the planning, implementation, and evaluation of family-centered services and systems, including outreach activities.
- Interagency agreements and contracts for addressing the needs of eligible children and families assure that policies and practices of all providers are culturally competent, family-centered, and maximize natural learning opportunities.
- A critical goal of EI is to enhance the capacities of families to meet the developmental needs of their children through information sharing, education, training in professional partnerships, and advocacy. Opportunities for culturally sensitive parent-to-parent support and mentoring are supported by the designated parent consultant agency and EI provider policy.

Key Goals for Increasing Family Participation:

- the dissemination of information about EI and transition in multiple languages and distribution of that information in the community
- the increased identification and participation of eligible infants and toddlers from underserved populations, especially those between birth and one year old

III. OVERVIEW OF EARLY INTERVENTION PROGRAM CYCLE

The following is a brief look at the events that take place while a child is in the EI System. In general, these events are listed in the chronological order that they are most likely to occur. However, given the dynamic relationship among children, families, and providers, the processes that support these events are likely to be intertwined. Each of these events and the processes that support them are explained further in the relevant sections of this document: Referral to Early Intervention, Entry into a Full Service Early Intervention Program, Child Evaluation and Eligibility Determination/Child and Family Assessment, Eligibility for Early Intervention Services, Individual Family Service Plan (IFSP), and Early Intervention Services.

The cycle of evaluation, assessment, IFSP development, provision of service, and review is a continuous process that occurs until a child is discharged (see Section XI) from the program at or before the child's third birthday. In addition, at 30 months a Transition Plan (see Section XI) must be developed to support the child and family as they leave EI. This Transition Plan should be coordinated with the evaluation, IFSP, and IFSP Review cycle.

IV. REFERRAL TO EARLY INTERVENTION

CHILD FIND SYSTEM

It is the goal of HEALTH that all infants and toddlers presumed eligible for EIS will be promptly and accurately identified, located, referred to EI, and evaluated. Individualized Family Service Plans (IFSPs) will be developed for all eligible children. Such IFSPs will accurately identify areas of need and address the goals of families in areas of identified need, and appropriate services as defined by the IFSP will be provided.

To ensure the goal of developing IFSPs for all EI eligible children, multiple agency linkages and avenues into EI are essential. In Rhode Island, these linkages include Universal Newborn Screening and direct referrals from many sources, including family outreach programs. Child Find efforts are coordinated with all state child find resources (e.g. Part B of IDEA, Maternal and Child Health {MCH}, Medicaid, Supplemental Security Income {SSI}), with the assistance of the Interagency Coordinating Council (ICC).

Entry points into EIS may occur through multiple avenues (see Appendix C). Screening and direct referrals are described below.

UNIVERSAL SCREENING

Consistent with a population-based orientation to screening, Rhode Island has an Interagency Agreement with the seven birthing hospitals in the state, which serves as the primary mechanism through which universal screening is conducted. This activity begins with the birth of an infant when, from a review of the information gathered in the nurseries of the birthing hospitals, an assessment of risk status is made. From this assessment, decisions are made regarding the need for follow-up upon discharge from the hospital or direct referral to EI. This process is known as Level I screening

One aspect of follow-up to universal screening is in-home screening (Level II screening), which is a comprehensive process that includes information on the child's developmental competence, family strengths, needs, and support systems, and the characteristics of the caregiving environment. Visiting Maternal and Child Health nurses, trained in assessment, from the Family Outreach Program (FOP) conduct this screening. One of the primary goals of this screening is to identify children and families in need of a multidisciplinary team evaluation by an EI provider and to assess other needs families may have so that referrals to appropriate community agencies are made.

Upon completion of this in-home screening, identified families are referred to EI when appropriate or to other community based services by the FOP programs.

REFERRAL

Direct Referrals: Direct referrals permit families, community-based agencies, and health care providers to refer infants and toddlers directly to EI for family assessment and evaluation. It is recommended that direct referrals be made within two days after the child is identified as being in need of EI evaluation and assessment. This referral can be made by telephone, fax, letter or in person.

When referrals come from community agencies or health care providers, it is expected that families were involved in the decision to make a referral to EI, as families can decline a referral to EI (except when mandated through the Department of Children, Youth and Families {DCYF}). Additionally, families may chose any full service provider regardless of home address. For example, if a family lives in Cranston but works and has child care in Providence, that family may choose to access an EI provider located in the Providence area. Referral sources will receive timely feedback (within 45 days) from the EI service provider on the status of the referral. The feedback to the referral source must be documented in each child's record.

Referrals will be accepted by EI providers for children up to their third birthday. For children who are older than 34 months, the focus of service coordination should be on coordinating evaluations and program planning with post-EI options. Families may also chose to work directly with their Local Education Agency (LEA) at this time. EI providers will facilitate a referral to the LEA to all families who choose this option.

Health Care Provider Linkage: A clear referral system as defined by HEALTH and its partner agencies will facilitate direct referrals to EI from health care providers and other professionals. In general, when there is probable eligibility for EI (i.e. diagnosis of an established risk condition), then a child should be referred directly to a full service EI provider. If probable eligibility does not exist, then families may be offered the option of a developmental and family screening through the FOP, families may however chose the more comprehensive evaluation and assessment available through EI, if they wish. EI providers will partner with HEALTH in assuring broad outreach to health care providers, informing them of the process for referring their patients to EI.

V. ENTRY INTO A FULL SERVICE EARLY INTERVENTION PROGRAM

Each EI provider, upon receipt of a referral, must meet the following requirements:

- A record is initiated. This record contains referral source, date, and reason(s) for referral, primary health care provider, services currently received, and demographic information for the child and family. Demographic information includes first and last name of child and parent(s), child's date of birth, contact address, telephone number if available and family's primary language. Any special circumstances regarding custody should also be noted. Final disposition of the referral must also be recorded in the child's record.
- An appointment of a service coordinator is made as soon as possible, after a referral is received
- Scheduling is done so that appropriate referrals for screening or for evaluation and assessment activities are completed to ensure that eligibility determination and an IFSP meeting are also completed within forty-five days of referral to the provider.
- Procedures are in place to ensure that families are informed, in writing, of the disposition of the referral, and of any activities (with timelines) which will be instituted on behalf of the child and family, given informed written consent by families.

These standards are typically met both through telephone contact with families, as well as through an intake visit which is most often in families' homes, although it may occur in other locations at the families' convenience.

The initial visits with families are conceptualized as opportunities to begin information sharing. Providers gather information regarding developmental history, family concerns or questions and begin to identify daily routines and activities. This information forms the basis for pre-assessment planning and lays the groundwork for IFSP development and relationship building. At the same time EI staff provides information regarding the purpose and philosophy of EI as well as procedural safeguards. It is during this period of initial contact that a financial intake/information meeting should occur with families.

The purpose of the financial intake/information meeting is to answer any questions families have regarding EI funding and to educate families about the questions they may wish to consider before authorizing EI to access private insurance as a potential funding source for services as defined in the IFSP.

Families may deny access to private insurance. If families chose not to use private insurance, providers may not require an explanation of this decision from families or provide different services to such families. Additionally, while it is permissible to gather information regarding type of insurance coverage, it is NOT permissible to request specific policy information (i.e., policy #) until a family has indicated that their private insurance may be used.

Other activities which typically occur during this time period are the signing of relevant releases and consents and informing families of the opportunity to meet with other parents through the parent consultant program. Generally, it is anticipated that the intake, financial intake, evaluation and assessment, and IFSP development will take place over a series of two to three visits with a family, so that the family will have opportunity to gather information, as well as develop questions and goals around their child's development.

VI. CHILD EVALUATION AND ELIGIBILITY DETERMINATION/CHILD AND FAMILY ASSESSMENT

Each family has a choice when referred to an EI provider to either have a screening completed through the VNA/Family Outreach Program or to receive a multidisciplinary team evaluation and assessment within forty-five days of the date of referral. If a screening indicates risk factors or delays then, with family consent, a referral for an EI evaluation will be made. It is recommended that families participate in the EI evaluation and assessment process if probable eligibility is known. If probably eligibility is known (i.e., an established condition has been diagnosed), families may avoid duplication and delay by a direct referral to EI. If probable eligibility is unclear, families may prefer the screening through FOP, as it is typically completed by one person in one visit, as opposed to an EI evaluation, which typically occurs over two visits with two or three people.

When the multidisciplinary team evaluation is selected and a child is determined eligible, evaluations occur at least annually thereafter until time of discharge. Evaluations and assessments should be conducted in collaboration with other state and/or community agencies when relevant. Information regarding appropriate natural environments and routines is gathered during the intake, evaluation, assessment and IFSP, so that the scheduling of the multidisciplinary team evaluation and assessment occurs at a time convenient for the family and in an environment most normal for that child.

The goals of the evaluation and assessment process not only include eligibility determination and gathering information for planning purposes, but also to provide answers to family questions regarding their child's development.

For each initial team evaluation and assessment and every annual evaluation and assessment thereafter, at least two members of a multidisciplinary team and a family member must be present and participate fully and actively in the process, as appropriate. Team members are chosen based on the areas of developmental concern and family questions.

Evaluations and assessments are conducted by qualified multidisciplinary team members trained to use appropriate methods and procedures. The evaluation and assessment includes a review of medical history and current health records and the use of two or more measures, including norm-referenced, criterion-referenced, parent report, and/or direct observational measures. Measures used must provide information about the child's level of functioning in each of the following areas: cognition, physical, including vision and hearing; communication; social or emotional development and adaptive development. With family consent, information regarding vision and hearing status should be obtained from the child's primary care physician. If vision and hearing information is not available, providers must make other arrangements for assessment of these areas.

At least one measure used in the evaluation and assessment must be norm- or criterion-referenced. A norm-referenced test is a test that compares the individual child's performance to a clearly defined normative group (i.e., comparing a two year old child's performance to that of a thousand other two year olds on the same tasks). A criterion-referenced measure compares an

individual's performance to established criterion or standard of performance. In most cases use of both a norm-referenced and criterion-referenced measure will provide the most complete information to determine eligibility and begin assessment of a child's current functioning for program planning.

If a criterion-referenced tool is used for the determination of eligibility, it must provide a developmental age or ages in the required domains. It is strongly recommended that norm-referenced measures be considered for the child's last evaluation before turning three years of age and exiting EI as norm-referenced information may be used in determination of eligibility for preschool services. Selection of the other tool(s) is based on the judgment of the evaluation team with family input as appropriate. In cases where eligibility is known, as is the case with a documented established condition (SEC), it is recommended that criterion-referenced measures be used in linking assessment to goals in the IFSP.

In those rare cases when a child's functioning is not measurable using norm-referenced tools or criterion-referenced measures, then the evaluation and assessment report should clearly delineate the child's level of functioning in each required area so that an independent evaluation team would make the same eligibility determination on the basis of the written report or in clinical observation of the child.

Participants in the multidisciplinary evaluation and assessment process use informed clinical opinion in interpreting observation, parent report, and other evaluation data.

Each EI provider must ensure that the following standards of evidence and nondiscriminatory practice are met:

- Tests, assessments, and other evaluation procedures are administered in the native language of the child and parent or other mode of communication, unless not feasible;
- Any evaluation or assessment procedure is selected and administered so as not to be racially or culturally discriminatory;
- No single procedure is used as the sole criterion for determining a child's eligibility for services; and
- Evaluation and assessment are conducted by qualified personnel.
- Evaluation and assessment procedures are consistent with the unique demographic, cultural, racial, and ethnic characteristics of the population serviced.

The intent of this is to ensure and promote equitable, reliable, and valid decision making within and across providers. In order to facilitate this process, HEALTH will maintain a compendium of instruments, measures, assessment procedures, and scales which is fully accessible to EI program staff and families (see Appendix D). While the use of specific instruments is not mandated by regulation, all domains of child and family functioning (with family consent) noted above *must* be represented in the evaluation and assessment process.

The EI providers are responsible for assisting those children and their families who are not eligible for EI services after evaluation but for whom continued concerns remain. If the family wishes, assistance is provided to ensure that a referral is made to appropriate community-based resources. When needed, this referral can be facilitated through an interagency review team (such as the Child Adolescent Service System Program{CASSP}, or the FOP, with family consent.

Evaluation means the procedures used by qualified personnel (see Section X) to determine a child's initial and continuing eligibility for EIS. Additional factors, including family factors (with family consent), are used in determining eligibility. Eligibility determination is delineated in greater detail in Section VII. EI providers *may* use evaluations completed by other agencies in eligibility determination if they meet the evaluation standards (that is, two professionals, two measures, and consideration of all areas listed above) and have been completed within the last three months. When an outside evaluation is used to determine eligibility, EI must still complete an assessment for planning purposes. This assessment must be conducted by a multidisciplinary team of at least two qualified personnel. If an outside evaluation also contains information that may be appropriate for program planning, such information must be reviewed by a multidisciplinary team of at least two qualified personnel for incorporation into the IFSP.

EI evaluation teams must consider any outside evaluations that parents may have and wish to have considered, however the EI evaluation and IFSP teams hold the responsibility of determining eligibility and services. In other words, the EI team is not obligated to follow eligibility decisions or recommendations made by non-EI staff. If parents, as members of the EI teams, disagree with the decisions made by other team members, then they may access procedural safeguards (Section XII).

Child Assessment refers to the ongoing procedures used by qualified personnel throughout the child's eligibility period for EIS to identify the child's unique strengths and needs and the services appropriate to meet those needs. This assessment, along with the family assessment, when available, form the basis for the goal development in the IFSP.

Family Assessment - With the voluntary consent of the parent(s), a family assessment process, conducted by personnel trained to use appropriate methods and procedures, may identify the needs of the family as related to appropriately supporting in the development of the child.

The assessment process includes specification of expressed family concerns, and incorporates the family's description of its resources, priorities, and concerns and the identification of the supports and services necessary to enhance the family's capacity to meet the developmental needs of the child. A variety of different methods may be used by multidisciplinary teams to gather this information, e.g., family self-report questionnaires, structured interviews, informal discussions, etc.

Linkages with other agencies and service providers to enhance the family's ability to support an eligible child's development are explored. In all instances, information is collected only if it serves a specific decision-making function, and parents and the service coordinator jointly

determine the method(s) for gathering this information. This information is recorded on the Family page of the IFSP.

Annual Re-evaluation - The purpose of the annual re-evaluation meeting is to determine continued eligibility. Annual re-evaluations must meet the same standards as the initial evaluation. The annual re-evaluation also provides information which, with information from ongoing assessment of the child and family, is used in revising and updating the IFSP. Participants in this evaluation may include those represented in the initial IFSP meeting or may be current service providers. If a child and family no longer meet the eligibility criteria, they must be discharged from the program at this point. A final service coordination visit is permitted prior to discharge. Families may be re-referred to EI or the FOP prior to the child's third birthday if concerns are noted at a later time.

VII. ELIGIBILITY FOR EARLY INTERVENTION SERVICES

There are three categories of eligibility for EI services: Children with Established Conditions, Established Developmental Delays, and Children at Significant Risk for Developmental Delays.

Children with Established Conditions (Single Established Condition-SEC): Children whose early development is influenced by diagnosed medical disorders of known etiology bearing relatively well-known expectancy for developmental outcome within varying ranges of developmental delay.

Criteria: The child has a physical or mental condition known to impact development, including, but not limited to, diagnosed chromosomal, neurological, metabolic disorders, or hearing impairments and visual impairments not corrected by medical intervention or prosthesis. (SEE APPENDIX E FOR A LIST OF REPRESENTATIVE CONDITIONS). Evidence of diagnosis must be in the child's record. When asked to provide ICD-9 codes for the purpose of HEALTH data collection, code single established conditions as primary.

Established Developmental Delays: Children who, during the period of infancy, or more commonly in the second year of life, begin to manifest developmental delays, often of unknown etiology.

Criteria:

- The child exhibits a delay in one or more areas of development (that is, 2 standard deviations below the mean in one area of development, or 1.5 standard deviations below mean in two or more areas of development), or if using developmental age or age equivalents, a delay greater than or equal to 25% in one or more areas of development.

The areas of development considered are cognitive development, physical development (including vision and hearing), communication development, social or emotional development, and adaptive development.

A child may qualify for EI due to concerns with articulation and/or dysfluency if such concerns represent a significant delay or disorder and are not developmental in nature.

Guidelines for delay when using age-based scores*:

<u>AGE</u>	<u>DELAY</u>
4 months or less	1 month
5-8 months	2 months
9-12 months	3 months
13-16 months	4 months
17-20 months	5 months
21-24 months	6 months
25-28 months	7 months
29-32 months	8 months
33-36 months	9 months

* 25% may be calculated on weeks (i.e., 25% is present when an eight-week old baby performs at a six-week old level) for any measure that provides that degree of specificity. Also note that delays less than 25% should be considered under multiple conditions and professional judgment.

When asked to provide ICD-9 codes for the purpose of HEALTH data collection, code established conditions before developmental delay; be as specific as possible in defining the type of delay. Code any relevant risk factors after developmental delay.

- **Professional Judgment:** A child who does not meet the above criteria for developmental delay can have provisional eligibility based on the professional judgment of a multidisciplinary team. A child who is deemed eligible for six months through professional judgment will receive an additional evaluation to determine further eligibility. Extensions of provisional eligibility are made through a special request to HEALTH.

Professional judgment is used for those children who have received a comprehensive evaluation and assessment and who, on the basis of expert judgment by members of the evaluation team, manifest significant and observable atypical behaviors which warrant EI services. Atypical behaviors may include difficulties in attachment and interaction with primary caregivers and family members, chronic feeding and sleep disturbances, precipitous changes in rate of development, difficulties with self-regulation, injurious behavior to self or others, as well as inappropriate or limited ways of engaging and/or forming relationships with peers or adults. In assessing the presence and quality of such atypical behaviors, the evaluation process must also involve the caregiver's ability to foster attachment (i.e., provide physical care and comfort, respond flexibly to infant cues and behavior).

Children at Significant Risk for Developmental Delays or Disorders (Multiple Established Conditions – MEC):

- Children with a history of prenatal, perinatal, neonatal, or early life events suggestive of biological insults to the developing central nervous system which, either singularly or collectively, increase the probability of later atypical development; and
- Children whose early life experience, including maternal and family care, nutrition, opportunities for expression of adaptive behaviors, and patterns of physical and social stimulation are of concern to the extent that they impart high probability for delayed development.

Criteria: As a guideline, any combination of four or more child and/or family characteristics would qualify a child for EI services. In those cases where a factor encompasses several subfactors, each subfactor is counted as one family or child characteristic.

CHILD CHARACTERISTICS

Note: Factors 1-5 apply only to children under 18 months chronological age. Parent report may be used to identify factors 1-5 for initial eligibility; however, it is expected that birth or medical records will be obtained to substantiate factors 1-5.

1. Gestational Age:
 - a. A child meets this risk criterion if the gestational age of the child is less than 32 weeks or more than 44 weeks.
 - b. Developmental evaluations for eligibility will be based on adjusted age, up until the child's second birthday.
2. NICU Admission: This risk criterion applies to a child with a stay in the Neonatal Intensive Care Unit of more than 72 hours
3. Apgar: A child meets this risk criterion if the child's Apgar score was less than 6 at one or five minutes.
4. Total Hospital Stay: Child will qualify as having the hospital stay risk factor if the total number of days as an inpatient in a hospital or extended-care facility exceeds 25 days in a six-month period. This does not apply to the birth admission of a premature child. Subsequent admissions to the birth hospital or to a transfer hospital after an NICU admission will apply toward this total.
5. Intrauterine Growth Retardation/Small for Gestational Age: Child meets this qualifying risk factor if diagnosed at birth with Intrauterine Growth Retardation (IUGR) or Small for Gestational Age (SGA).
6. Weight or Height for Age:
 - a. A child meets this risk factor when weight for age or height for age or weight for height is less than the 5th percentile.
 - b. A child meets this risk factor if the weight for age has dropped two or more major centiles in three months if the child is under 12 months of age or has dropped two or more major centiles in six months if the child is 12 to 36 months of age. A major centile is defined as the major percentiles (5, 10, 25, 50, 75, 90, 95) on the Physical Growth Chart adopted by the National Center for Health Statistics.
 - c. The above two measurements should be used on the appropriate growth chart approved by the National Center for Health Statistics.
7. Chronic Feeding Difficulties: A child meets this eligibility risk criteria if any of the following conditions exist over an six month period of time:

- Severe colic
- Refusal or inability to eat
- Stressful or intensely conflicted feedings
- Failure to progress in feeding skills
- Severe obesity

Evidence of this risk criteria should be documented in the child's record and appropriate goals and treatment strategies addressed as determined by the family.

8. Insecure Attachment/Interactional Difficulties: A child meets this risk criteria if the child appears to have trouble with social relationships, depression, or indiscriminate aggressive behavior.

In most contexts, insecure attachment in infants and toddlers is evidenced by behavior such as persistent failure to initiate or respond to social interactions, fearfulness or fearlessness that does not respond to comforting by caregivers, or indiscriminate sociability.

If a child manifests significant and observable atypical behaviors, that child may qualify for EI services under developmental delay on the basis of a comprehensive evaluation and assessment using the judgment of the evaluation team.

9. Lead Blood Levels: A child meets this eligibility risk criteria when diagnosed with Significant Childhood Lead Poisoning as defined by the Center for Disease Control as of 2002.

10. Suspected Central Nervous System (CNS) Abnormality: Suspected CNS abnormalities may include, but are not limited to, the following:

- Infection: sepsis HIV (+)-indeterminant infection and/or maternal infection during pregnancy with known effect on fetal development
- Trauma: intracranial hemorrhage, subdural hematoma
- Metabolic: hypoglycemia, seizures (controlled) associated with electrolyte imbalance, neonatal hyperbilirubinemia (greater than 20 mg/dl), acidosis
- Asphyxia: prolonged or recurring apnea, aborted SIDS, suffocation, hypoxia, meconium aspiration, near drowning
- Exposure to noxious substances in utero, including prenatal drug and alcohol exposure

This category may also include the following clinical findings:

- Abnormal muscle tone
- Multiple apnea episodes inappropriate for gestational age
- Abnormal sleep patterns/disturbances
- Inability to feed orally
- Persistence of multiple signs of sensory impairment or less than optimal sensory and motor patterns, including hypertonicity and over-reaction to auditory, visual or tactile input

- Respiratory Distress Syndrome
11. Multiple Trauma/Losses: A child meets this criterion if he/she has experienced a series of traumas or extreme losses that may impact on the care and/or development of the child. This risk factor should be documented in the child's record and appropriate goals and strategies specified. This risk factor includes a child with a confirmed history of abuse or neglect and/or multiple placements outside the biological home.
 12. Mild Developmental Delay: Delay between 1.5 and 2.0 standard deviations below the mean in one area or less than 1.5 standard deviations below the mean in two or more areas.
 13. Medical Diagnoses with Associated Risk: If any of the these diagnoses are present with a delay equal or greater to 1.5 SD below the mean in any developmental area, then the child should be deemed eligible under Multiple Established Conditions. The following is a listing of medical diagnoses that may impact development (with a lesser probability than those conditions listed as Established Conditions), including, but not limited to:

Genetic Disorders

- DiGeorge Syndrome
- Goldenhar Syndrome/hemifacial Microsomia/Oculoauriculo Vertebral Moebius Syndrome
- Pfeiffer Syndrome
- Pierre-Robin Syndrome
- Treacher Collins Syndrome
- VATER Association

Sensory Impairments

- Chronic Otitis Media (for more than six months)
- Chronic Middle Ear Effusion (for more than six months)

Motor Impairments

- Brachial Plexus Palsy
- Hand Deformity
- Limb Deformity
- Missing Limb
- Torticollis

Childhood Malignancies

- Astrocytoma
- Leukemia
- Neuroblastoma
- Retinoblastoma

Neurologic Disorders

- Erb's Palsy

Medically Related Disorders

- Cleft Lip Complete
- Complex Cyanotic Heart Disease
- Craniosynostosis
- Cystic Fibrosis
- Esophageal Atresia
- Juvenile Rheumatoid Arthritis
- Laryngomalacia
- Severe Malabsorption
- Sickle Cell Disease
- Tracheoesophageal Fistula/TEF

FAMILY CHARACTERISTICS

Regarding children in the care of someone other than the child's biological parent, if the goal is for the reunification of the parent and the child, the following risk factors apply based on the biological parent. If there is no goal for reunification with the child's biological parents (i.e., a Termination of Parental Rights has been finalized), the family risk factors are to be based on the family characteristics of the primary caregivers.

Determination of risk factors under family characteristics should be determined by sound clinical practice including family input.

Maternal characteristics apply as risk factors to fathers if the father is the primary caregiver.

1. Maternal Age/Parity: A family meets this eligibility risk factor if the maternal age at the time of the child's birth was less than 18 or if the mother has given birth to three or more children before age of 20.
2. Maternal Education: A family meets this eligibility risk factor if the educational level of the mother is 12th grade or less at the time of the eligibility evaluation.
3. Parental Chronic Illness or Disability: A family meets this eligibility criterion if one parent has a diagnosed chronic illness or sensory (including vision and/or hearing), mental, or developmental disability which is likely to affect the child's development or have an impact on caregiving ability. Examples of this risk factor may include affective disorders (e.g., depression), schizophrenia, and cognitive limitations.
4. Family Lacking Social Supports: A family meets this risk criterion if the family is geographically or socially isolated and in need of emotional support services. This risk factor should be documented in the child's record and appropriate goals and strategies specified as determined by the family.

5. Family Lacking Adequate Food, Clothing, or Shelter: A family meets this risk factor criterion if the lack of food, clothing, or a stable housing arrangement causes life stress for the family. This risk factor should be documented in the child's record and appropriate goals and strategies specified as determined by the family.
6. Open or Confirmed Protective Service Investigation: A family meets this risk factor criteria if the family has an open protective service file with the Department of Children, Youth and Families, or is in the period of investigation of child abuse or neglect, or had its file closed by DCYF in the last three months. A family who is receiving voluntary services from the Department of Children, Youth and Families may also meet this criterion. This risk factor should be documented in the child's record and appropriate goals and strategies specified as determined by the family.
7. Substance Abuse: A family meets this risk factor if substance abuse is having or may have an adverse affect on the child's development. This risk factor should be documented in the child's record and appropriate goals and strategies specified as determined by the family.
8. No or inadequate prenatal care: A family meets this risk factor if the mother received no prenatal care prior to the fifth month of pregnancy.

VIII. INDIVIDUALIZED FAMILY SERVICE PLAN (IFSP)

REQUIREMENTS OF IFSP MEETINGS

For each child evaluated for the first time and deemed eligible for EI services, the IFSP meeting is conducted and an IFSP is prepared no later than forty-five days after referral. An IFSP will be completed minimally on an annual basis (by or on the date of the previous year's IFSP), utilizing information from the annual re-evaluation and ongoing assessment until the child is discharged from EI.

All IFSP meeting are conducted:

- By a meeting. Other means acceptable to the parents and other participants may be used to complete an IFSP in extenuating circumstances, which are documented in the child's record.
- In the native language of the family or other mode of communication used by the family, unless not feasible. When not feasible to conduct the IFSP in the language of the family, an interpreter must be present to facilitate the family's full participation and decision making as part of the IFSP team.
- In settings and at times that are convenient to families. Scheduling should occur with families.
- In accordance with federal law, written notification should be provided to the family and all other participants by the service coordinator at least seven days prior to the date of the Initial and Annual IFSPs to ensure attendance. The family may waive this requirement if they so choose. Documentation that written notice has been waived must be signed by the parent(s) and maintained in the child's file.

Each initial IFSP meeting and each annual IFSP thereafter, must minimally include the following participants:

- the parents or guardian of the child
- other family members as requested by the parent
- an advocate or person outside of the family as requested by the parent
- the service coordinator working with the family
- at least one professional who participated in the evaluation and assessment process. This professional may be the service coordinator if the service coordinator acted as one of the team of evaluators
- as appropriate, service providers of the child and family

If any persons directly involved in conducting evaluations and assessments are unable to attend the meeting, arrangements are made for other methods of participation, (e.g., telephone calls, introduction of pertinent records available, knowledgeable authorized representatives present, etc.)

It is important to note that information contained within the IFSP, such as diagnoses, medical conditions, test results, and service goals should be presented in language and in a format that is easily understood by families. The final content of the IFSP is jointly determined and agreed to by the family and service coordinator.

Informed written consent (through signature on the IFSP) must be obtained before the provision of the EIS described in the IFSP. If parents do not provide consent for a particular EIS or withdraw consent after initially providing consent, that service may not be provided. Those EIS to which parents consent must be provided (see Section XII for more information). Additionally, it is required that the IFSP be shared with the child's primary care physician (PCP), given family consent. Information from the PCP regarding health and immunization status is needed before a child can participate in group placements (unless a written objection based on religious grounds is signed by the parents).

In the event a dispute exists within agencies regarding development or implementation of the IFSP, HEALTH will resolve the dispute or assign responsibility for service provision (see Section XII for more information).

REQUIREMENTS FOR IFSP CONTENT

All IFSPs must be completed on the most recent IFSP form issued by HEALTH. This document must be completed in its entirety for each initial and annual IFSP. Additional information regarding the completion of the IFSP is available in Appendix F. It should be noted that HEALTH believes that the process of completing the IFSP is as important as the written product. The expected process is that goals are written together with families and other caregivers rather than being written by professionals and given to parents for review and approval. As families are equal partners in the development of the written IFSP, the written IFSP should be unique, as is the family who participated in its development.

Rhode Island's IFSP contains the following essential requirements:

Designation of Service Coordinator: Name of the service coordinator from a profession most immediately relevant to the child's or family's needs (or otherwise qualified to carry out all applicable responsibilities) who will be responsible for implementing the IFSP and coordinating with other agencies and persons. As used here, the term "profession" includes "service coordination."

Family Information: With the permission of the family, the IFSP includes a statement of family resources, priorities, and concerns, related to enhancing the development of the child.

Child Status: Describes a child's current level of functioning within the areas of physical development (including vision and hearing and health status), cognition, communication development, emotional or social development, and adaptive development. Present levels of development are based upon professionally accepted objective criteria, as well as informed clinical opinion.

Goals/Outcomes: A statement of the major outcomes expected to be achieved for the child and family, and the criteria, procedures, and timelines used to evaluate such outcomes, including the degree to which progress toward achievement is being made, and if modifications of outcomes or services are necessary.

Array of Services: A statement of the specific EIS necessary to meet the unique needs of the child and family. Such statements must include the frequency and intensity of service. "Frequency" and "intensity" mean: The *number* of days/sessions a service is provided, the *length* of time the service is provided during each session, and whether the service is provided on an *individual* or *group* basis. The statement must also include location, method of delivery of service, payment arrangement, and natural environments in which the service is provided, and a justification of the extent, if any, to which the services will not be provided in a natural environment.

Dates: The projected dates for initiation of service and the anticipated duration of the service.

Transition: Specification of activities that will occur to support the smooth and effective transfer of children from EI to other environments at three years of age is specified in a written Transition Plan.

CONSIDERATIONS REGARDING CLINICAL PRACTICE WITHIN THE IFSP

The IFSP is the cornerstone of EI; therefore, several key concepts of EI are embedded within the IFSP. The first concept that runs throughout the IFSP is family-centered practice and service. The family's expertise and experience of their child is recognized, and families are considered to be full team members in the IFSP process, as well as in service delivery.

Families are unique, and components of that uniqueness include ethnicity, race, religion, language, values, belief, and financial circumstances. In order to be family centered, EI service providers must provide services that respect the diversity of families. Thus EI service providers must seek knowledge and skills to be culturally competent. These skills include an awareness of the impact of culture on behavior (including the service provider's own behavior), the ability to ask for and use information from families about who they are and how we can best respond to their needs, and the ability to locate resources within communities to help provide culturally competent support to families.

A second concept that is critical in the development of an IFSP is that goals must be meaningful to families and children. Meaningful goals are goals that are both developmentally appropriate

and appropriate within the context of families' everyday lives and their desired outcomes for their children. Goals that are developmentally appropriate will recognize that play and the integration of developmental domains within the context of play are essential to promote the learning of all children.

The concept of meaningful goals that respect families and the development of young children is closely linked with the concept of natural environments (natural learning opportunities). This concept has two key components. The first component is that one of the most important outcomes that we can support is for young children with special needs to fully participate in their everyday world, rather than be excluded from life experiences that other children have. EI efforts are directed towards removing barriers to participation for children in a variety of ways, ranging from adapting environments to the use of technology.

The second component of natural environments encompasses the knowledge that children learn best in the context of everyday routines, activities, and places. Routines are those events that are part of a family's schedule (i.e., bath time). Activities are those things that families do together (go shopping, visiting a friend). Everyday places are those places that children and families go together (day care, the library). Routines, activities, and places offer rich learning opportunities, including the opportunities for generalization, that cannot be replaced by contrived learning situations. When strategies to obtain meaningful goals are developed using the what, the who, the how, and the when of natural environments, change is likely to occur for children and families. (Adopted from Edelman (2001) "Just Being Kids: Facilitator's Guide." Denver. JFK Partners, University of Colorado Health Sciences Center and Early Childhood Connections, Colorado Department of Education)

It should be emphasized that providing services in natural environments does NOT simply mean offering services in the home and other settings but DOES offer a different model of service delivery that fully engages children and their families in using natural learning opportunities to enhance development. This model encourages the full participation of children who receive EI services in the world of all young children.

For those circumstances whereby it can be clearly demonstrated and documented that progress toward developmental goals cannot be reached in natural environments, it is possible to provide services in other locations. This decision to provide services in other locations must be made by the IFSP team. The justification for this decision must be based on child and family need and documented in the IFSP.

The IFSP must also contain information regarding a plan and proposed timeline for moving toward service delivery in natural environments, as well as a plan for how strategies used in locations that do not meet the definition of natural environments will be generalized to locations that do.

For success in serving a child in his/her natural environment, EI providers must have solid working relationships with a broad array of groups, agencies, places of worship, and individuals that are part of the community in which the child and family lives. Demonstration of solid relationships in the communities that will partner with EI to serve children in natural

environments is a major component of the vision that HEALTH holds for EI providers. This is a major factor in the HEALTH requirement as indicated in the Certification Standards that each EI provider participates and documents participation in community activities (see Section XIII for information on community involvement requirements).

IFSP PROGRESS REVIEW

Given the dynamic nature of the developmental course of infants, toddlers, and their families, IFSPs require ongoing review, discussion, and revision by parents and service coordinators. EI providers must have procedures that promote and facilitate continuous, collaborative planning by professionals and families.

In addition to such ongoing exchanges, each IFSP must be formally reviewed every six months, or more frequently if conditions warrant, or if a family requests such a review. Participants in this progress review minimally include the parent, service coordinator, and other select team members as requested by the parent. Optimally these other team members include community members to obtain the value inherent in a diversely constituted IFSP team.

This review occurs through a meeting or other means acceptable to the parents and other participants. The objective of this meeting is to review the degree to which progress is being made toward achieving outcomes and whether modifications or revisions of outcomes or services are needed. Please note that parental written consent through the IFSP and IFSP review process must be obtained before services can be initiated, altered or ended. Providers may not terminate a service unilaterally either based on attendance or the clinician's perceived attainment of the IFSP goals. If an IFSP or IFSP review can not be scheduled due to extenuating circumstances then the provider must present any proposed changes in services in writing to the family in accordance with procedural safeguards (see Section XII).

INTERIM IFSP

In exceptional circumstances when probable eligibility is present and there is documentation that EI services are needed immediately or when team evaluations and assessments cannot be completed within 45 days due to child or family circumstances, all referred children and families should receive a comprehensive in-home visit. The purpose of this visit is to determine probable eligibility (if not already known) and to complete an interim IFSP. EI program staff conducts such screenings, or screenings can be done by a Title V, MCH sponsored visiting nurse association (FOP), as specified in the Interagency Agreement.

The interim IFSP is developed by an EI service coordinator in conjunction with parents. Exceptional circumstances must be documented and an interim IFSP developed and implemented, with parents' written consent. This interim IFSP must include the name of the service coordinator responsible for implementation of the interim IFSP. It must also include a plan for completing the full evaluation and assessment, as well as completing the full IFSP within 45 days, or as soon as possible in the case of exceptional circumstances. In addition, the

interim IFSP must include a plan for coordination with other agencies and persons as needed, as well as documentation that EI services are needed immediately.

UNDER NO CIRCUMSTANCES CAN AN INTERIM IFSP BE DONE IN PLACE OF A FULL IFSP AS A RESULT OF PROGRAM STAFFING OR SCHEDULING ISSUES.

If a delay in completing the IFSP results from families not being able to keep scheduled IFSP meetings, then the EI provider must document attempts to schedule with the family and strategies employed by the provider to identify and assist with whatever barriers are impacting upon the family's ability to attend the IFSP meeting(s).

IX. EARLY INTERVENTION SERVICES (EIS)

EI providers and staff coordinate the appropriate services each child and family needs as written in the IFSP. This means that EI providers can either provide the services directly, contract for the services, or coordinate services. Coordinating services means both helping families access services with appropriate funding streams (i.e., DHS funding for an integrated group) and ensuring the integration of services that are funded by EI with those that are funded through other sources. However, it is anticipated that providers will be moving toward providing 90% of services directly to maximize coordination of services and support a transdisciplinary approach.

The definitions (based on IDEA, Section 303.12) of mandated EI services follow. Each EI provider must have access to all of the following services for all of the children whose IFSP documents the need for such services. Need is based on evaluation and assessment information, as well as on the goals of the IFSP. Additional services required by HEALTH are outlined in Additional Services/Programs.

It should be noted that goals and strategies **MUST** be developed in collaboration with a child's family before services are identified. It should also be noted that while services are delineated for the sake of clarity, that no single service is the sole focus of EI. Rather EI is a developmental and educational program with an emphasis on the whole child in the context of their family and community.

Thus family education and partnership in delivery of services is essential, as is the use of services to maximize natural learning opportunities. Equally important are the relationships that families build within their communities with the support of EI service providers.

Please refer to the Early Intervention Reimbursement Process Procedures for instructions on how to request for reimbursement for these services. The assumption is that service rendered forms will be signed for all face to face contact with families.

Assistive Technology Device

Any item, piece of equipment, or product system, whether acquired commercially off the shelf, modified, or customized, used to increase, maintain, or improve the functional capabilities of children with disabilities

Assistive Technology Service

A service that directly assists a child with disabilities in the selection, acquisition, or use of an assistive technology device, and includes:

- Evaluation of a child's needs, including a functional evaluation of the child in the child's customary environment
- Purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices by children with disabilities

- Selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices
- Coordinating and using other therapies, interventions, or services with assistive technology devices, such as those associated with existing education and rehabilitative plans and programs
- Training and technical assistance for a child with disabilities or, if appropriate, the child's family
- Training and technical assistance for professionals (including individual providers of EI Services) or other individuals who provide services to or are substantially involved in major life functions of individuals with disabilities

Audiology

Includes:

- Identification of children with audiological impairment using at risk criteria and appropriate audiological screening techniques;
- Determination of the range, nature, and degree of hearing loss and communication functions by use of audiological evaluation procedures;
- Referral for medical and other services necessary for habilitation or rehabilitation of children with auditory impairments;
- Provision of auditory training, aural rehabilitation, speech reading and listening device orientation and training, and other services;
- Provision of services for prevention of hearing loss; and
- Determination of the child's need for individual amplification, including selecting, fitting, and dispensing appropriate listening and vibrotactile devices, and evaluating effectiveness of those devices.

Family Training/Counseling/Home Visits

Services provided, as appropriate, by social workers, psychologists, and other qualified personnel to assist the family of an eligible child in understanding the special needs of the child and enhancing the child's development

Health Services

Services necessary to enable a child to benefit from other EI Services during the time the child is receiving the other EI services. The term includes such services as clean, intermittent catheterization, tracheotomy care, tube feeding, the changing of dressings or colostomy collection bags and other health services. Such services are most often accessed through in-home nursing. When such services are provided through in-home nursing, the service coordinator must assist the family in coordinating nursing services with other EI services. The term also includes consultation by physicians with other service providers concerning the special health care needs of eligible children that will need to be addressed in the course of providing other EI Services. The term does not include services that are:

- Surgical in nature (e.g., cleft palate repair, surgery for clubfoot or the shunting of hydrocephalus); or purely medical in nature (such as hospitalization for management of congenital heart ailments, or the prescribing of medicine or drugs for any purpose)
- Devices necessary to control or treat a medical condition
- Medical-health services (such as immunization and regular "well baby care") that are routinely recommended for all children

Medical Services Only for Diagnostic or Evaluation Purposes

Services provided by licensed physicians to determine a child's developmental status and need for EI Services

Nursing Services

Includes:

- Assessment of health status for the purpose of providing nursing care, including identification of patterns of human response to actual or potential health problems
- Provision of nursing care to prevent health problems, restore, or improve functioning and promote optimal health and development
- Administration of medications, treatments, and regimens prescribed by a licensed physician
- Such services are most often accessed through in-home nursing. When such services are provided through in-home nursing, the service coordinator must assist the family in coordinating nursing services with other EI services. This also includes consultation by physicians with other service providers concerning the special health care needs of eligible children that will need to be addressed in the course of providing other EI Services.

Nutrition Services

Includes:

- Conducting individual assessments in nutritional history and dietary intake; anthropometric, biochemical, and clinical variables; feeding skills and feeding problems; and food habits and food preferences
- Developing and monitoring appropriate plans to address nutritional needs of eligible children based on assessment findings
- Making referrals to appropriate community resources to carry out nutrition goals

Occupational Therapy

Includes services to address functional needs of a child related to adaptive development, adaptive behavior and play, and sensory, motor, and postural development. These services are designed

to improve the child's functional ability to perform tasks in home, school, and community settings and include:

- Identification, assessment, and intervention
- Adaptation of the environment and selection, design, and fabrication of assistive and orthotic devices to facilitate development and promote acquisition of functional skills
- Prevention or minimization of the impact of initial or future impairment, delay in development, or loss of functional ability

Physical Therapy

Includes services to address the promotion of sensorimotor function through enhancement of musculoskeletal status, neurobehavioral organization, perceptual and motor development, cardiopulmonary status, and effective environmental adaptation. These services include:

- Screening, evaluation, and assessment of infants and toddlers to identify movement dysfunction
- Obtaining, interpreting, and integrating information appropriate to program planning to prevent, alleviate, or compensate for movement dysfunction and related functional problems
- Providing individual and group services or treatment to prevent, alleviate, or compensate for movement dysfunction and related functional problems

Psychological Services

Includes:

- Administering psychological and developmental tests and other assessment procedures
- Interpreting assessment results
- Obtaining, integrating, and interpreting information about child behavior and child and family conditions related to learning, mental health, and development
- Planning and managing a program of psychological services, including psychological counseling for children and parents, family counseling, consultation on child development, parent training, and education programs

Service Coordination

Includes:

- Assisting parents of eligible children in gaining access to the EI services and other services identified in the IFSP
- Coordinating the provision of EI services and other services (such as medical services for other than diagnostic and evaluation purposes) that the child needs or is being provided
- Facilitating the timely delivery of available services
- Continuously seeking the appropriate services and situations necessary to benefit the development of each child being served for the duration of the child's eligibility

Specific service coordination activities include:

- Coordinating the performance of evaluations and assessments
- Facilitating and participating in the development, review, and evaluation of IFSPs
- Assisting families in identifying available service providers
- Coordinating and monitoring the delivery of available services
- Informing families of the availability of advocacy services
- Coordinating with medical health providers
- Facilitating the development of a transition plan to preschool services, if appropriate

Service Coordinators may be employed or assigned in any way permitted under State law as long as it is consistent with Part C requirements. The State policy and procedures for implementation of EI services must be designed and implemented to ensure service coordinators are able to carry out the above listed functions and services on an interagency basis.

Social Work Services

Includes:

- Making home visits to evaluate a child's living conditions and patterns of parent-child interactions
- Preparing a social or emotional developmental assessment of the child within the family context
- Providing individual and family-group counseling with parents and other family members, and appropriate social skill-building activities with the child and parents
- Working with those problems in a child's and family's living situation (home, community, or any center where EI services are provided) that affect the child's maximum utilization of EI services
- Identifying, mobilizing, and coordinating community resources and services to enable the child and family to receive maximum benefit from EI Services

Special Instruction

Includes:

- The design of learning environments and activities that promote the child's acquisition of skills in a variety of developmental areas, including cognitive processes and social interaction
- Curriculum planning, including the planned interaction of personnel, materials, and time and space, that leads to achieving the outcomes in the child's IFSP
- Providing families with information, skills, and support related to enhancing skill development of the child
- Working with the child to enhance the child's development

Speech-Language Pathology

Includes:

- Identification of children with communicative or oropharyngeal disorders and delays in development of communication skills, including the diagnosis and appraisal of specific disorders and delays in those skills
- Referral for medical or other professional services necessary for habilitation or rehabilitation of children with communicative or oropharyngeal disorders and delays in development of communication skills
- Provision of services for the habilitation, rehabilitation, or prevention of communicative or oropharyngeal disorders and delays in development of communication skills

Transportation and Related Costs

Includes the cost of travel for the family (e.g., travel by taxi, common carrier, or other means) and other costs (e.g., tolls and parking expenses) necessary to enable an eligible child and the child's family to receive EI Services

Families and EI provider staff collaborate to develop a range of transportation options, including car pools, public transportation, use of municipally owned cars and vans, and other state or privately supported transportation systems. For all eligible children and families, such transportation information and options must be made available; however, *under no circumstances* are required EI services to be withheld if transportation is unavailable. For families in which all of the above options have been exhausted, the EI provider assumes financial responsibility for providing safe and secure transport to the above mentioned service options. The EI provider must also comply with any applicable law and regulation regarding the use of car seats.

Vision Services

Includes:

- Evaluation and assessment of visual functioning, including diagnosis and appraisal of specific visual disorders, delays, and abilities
- Referral for medical or other professional services necessary for habilitation or rehabilitation of visual functioning disorders, or both
- Communication skills training, orientation, and mobility training for all environments, visual training, independent living skills training, and additional training necessary to activate visual motor abilities

Interpretation

Not a service per se, but a requirement to ensure that families are fully informed when asked to give consent, are able to access the procedural safeguards and are able to fully participate in service delivery.

Additional Services/Programs:

In addition to the "types of EI services" specified in the federal law, each EI provider is responsible for making available and/or securing access to the following array of services for eligible children and families, if they are appropriate: Developmental Monitoring, Integrated Group Programs, Consultation to Child Care Programs, Child Focused Developmental/Educational Group, Parent/Child Groups, Family/Child Directed Therapy, Parent Education, Support, and Guidance and Support for Siblings/Family Group.

These services are utilized to meet identified outcomes (goals) related to enhancing child development that are identified through the assessment and IFSP processes. See service definitions in the HEALTH issued Reimbursement Guide for additional expectations regarding these services. The provision of any of these additional services must be written into the IFSP to address child development goals.

It is important to note that such service options are intended to be viewed as an array or constellation of services rather than a graduated continuum. As such, children are neither required nor expected to move sequentially from one option to the next. Rather, it is anticipated that children and families will receive and participate in multiple service options concurrently, and not be restricted by a single service. Furthermore, all are to be provided within the context of the commitment to maximizing natural learning opportunities and community integration. Again, the sequence of presentation of these options is in no way intended to influence or determine the options received by eligible children and families.

Finally, the effectiveness of the above options listed as "additional services" depends substantially upon continuity of service provision, and therefore, EI support must be fully and conveniently accessible to eligible children and families in such service options. Providers are required to provide accessible, community-based arrays of service to parents, transportation of children to participate in these service options is assumed by parents, wherever feasible. However, if lack of available transportation would preclude participation in these services, the EI provider must assume financial responsibility for transportation (see also "Transportation and Related Costs").

Providers must also ensure that families have access to Parent Consultant services. These services include but are not limited to peer support as well as technical assistance regarding program questions and procedural safeguards. As it is assumed that Parent Consultant services are available to all parents who choose to access them, such services do not have to be written into the IFSP. However, it is required that a Parent Consultant be identified on each IFSP.

X. SERVICE PROVIDERS AND ROLES

PROFESSIONAL AND PARAPROFESSIONAL CREDENTIALS AND CERTIFICATION

All professional personnel in EIP, whether employed on a full-time or part-time basis, or under a contractual agreement, for whom certificates, licenses, or registrations are required by state law and regulation, must hold such certificates, licenses, or registrations. Only those professionals that hold such certificates, licenses, or registrations may be considered qualified professionals for the purposes of multidisciplinary team evaluations. Such professionals are designated as Service Coordinators II. Copies of these documents must be maintained on site for review by HEALTH and parents, as requested.

In Rhode Island, appropriate professional requirements means entry level requirements that:

- are based on the highest requirement in the State applicable to the profession or discipline in which a person is providing EIS, and
- establish suitable qualifications for personnel providing EIS under Part C to eligible children and their families who are served by state, local, and private agencies.

Highest requirements in the State applicable to a specific profession or discipline means highest entry-level academic degree needed for state approved or recognized certificate, license, registration, or other requirements that apply to a profession/discipline.

Profession or Discipline means a specific occupational category that provides EIS to children eligible under Part C and their families, has been established or designated by the state, and has a required scope of responsibility and degree of supervision.

State approved or recognized certificate, licensing, registration or other comparable requirement means that state legislation has enacted or authorized a state agency to promulgate rules to establish entry-level standards for employment in a specific profession or discipline in the state.

In short, all personnel in Rhode Island who provide EIS to children and families must meet the highest entry level requirement in the state for their respective profession or discipline, as defined above.

More detailed information regarding the operationalization of these standards follows. This information regarding personnel standards in Rhode Island is based on current information that accurately describes, for each profession or discipline in which personnel are providing EIS, that the applicable standards are consistent with the highest entry level requirements in Rhode Island for that profession or discipline.

HEALTH assures that policies and procedures have been developed which establish and maintain standards to ensure those personnel necessary to provide EIS to eligible children and

their families are appropriately prepared and trained. These standards are consistent with the approved certification and licensure requirements of the State, which apply to the profession or discipline in which a person is providing EIS. Standards are in the process of development for paraprofessionals.

In the identification of the “highest entry level requirements in the State” (RI Rules and Regulations, June, 1993 {R-23-13-EIS}) for purposes of this section, the requirements of all state statutes and the rules of all state agencies applicable to serving eligible children and their families were considered. The following standards are required for EI staff. These standards are listed by discipline.

<u>Discipline</u>	<u>Highest Entry Level Standard</u>
Audiology	Master's Degree with specific course content from an accredited program and meets requirements for licensure by HEALTH
Early Childhood Education	Bachelor's Degree from an accredited program and is certified by the Rhode Island Department of Education as an Early Childhood Teacher
Family Therapy	Completion of a graduate degree from an accredited program and is licensed by HEALTH
Medicine (Physicians)	MD (Doctorate in Medicine) State licensure and Board eligible or certification in appropriate medical or surgical specialty; must be licensed by Rhode Island Board of Medical Licensure and Discipline
Nursing	Licensed as a Registered Nurse by HEALTH and has graduated from Board approved and accredited nursing program
Nutrition	Bachelor's Degree in nutrition or dietetics from an accredited/approved program and is licensed by HEALTH
Occupational Therapy	Bachelor's Degree from an approved, accredited Occupational Therapy program and is licensed by HEALTH
Occupational Therapy Asst.	Certified Occupational Therapist Assistant Associate's Degree and passing National Occupational Therapist Examination for Occupational Therapist Assistant
Physical Therapy	Bachelor's Degree from a Board approved school of Physical Therapy and licensed by HEALTH

Physical Therapy Asst.	Physical Therapist Assistant Associate's Degree and passing National Physical Therapist Examination for Physical Therapist Assistant
Psychology	Doctoral Degree in psychology or equivalent programs licensed by HEALTH
School Psychology	Advanced degree from an approved program in school psychology and certified by the Rhode Island Department of Education
Social Work	MSW from an accredited program, certified and is licensed by the Rhode Island Board of Social Work
Special Education:	
Blind/Partially Sighted	Bachelor's Degree from an accredited program and is certified by the Rhode Island Department of Education as a Special Educator - Blind/Partially Sighted
Deaf/Hard of Hearing	Bachelor's Degree from an accredited program and is certified by the Rhode Island Department of Education as a Special Educator - Deaf/Hard of Hearing
Early Childhood	Bachelor's Degree from an accredited program, has an Early Childhood Teacher's certificate, and meets requirements for certification by the Rhode Island Department of Education as a Special Educator - Early Childhood
Speech and Language	Master's Degree with specific course content from an approved program or its equivalency and is licensed by Health
Speech and Language Pathologist Assistant	Completion of 18 graduate credits from an accredited program and registration with the Rhode Island Department of Health

There are other categories of professionals and paraprofessionals who may be employed by EI providers. The roles and requirements of those categories follow:

JOB TITLE: EARLY INTERVENTIONIST

QUALIFICATIONS: Associate Degree in Human Services or a related field and minimum of 1 year experience providing services to families with infants and toddlers; or High school diploma

or equivalent and minimum 3 years experience providing services to families with young children and bilingual in language relevant to the agency's population.

CONTINUING EDUCATION REQUIRMENTS: Minimum of 12 hours per year of inservice training with a focus on working with young children with disabilities and their families including the completion of the Introduction to EI course within 6 months of date of employment. Agency support for Early Interventionists to obtain their Bachelor's Degree is strongly encouraged.

RESPONSIBILITIES: Works under direct supervision of EI qualified personnel (service coordinator II) or their equivalent. Carries out responsibilities such as assisting in activities with individual children and families and groups of EI children and families in natural environments, unless otherwise justified. Does not have sole responsibility for a caseload.

SUPERVISION: Participates in individual supervision with EI qualified personnel or clinical supervisor a minimum of 2 hours/week, in addition to staff meetings.

STARTING SALARY: \$16,993 - \$21,862 based on 40 hours/week (hourly wage: \$8.17 - \$10.51)

JOB TITLE: SERVICE COORDINATOR I

QUALIFICATIONS: Bachelor's degree in early childhood education, child development, early childhood special education, social work, psychology, communication disorders, nutrition, or a related EI field.

CONTINUING EDUCATION REQUIREMENTS: A minimum of 12 hours per year of inservice training with a focus on working with young children with disabilities and their families, including the completion of the Introduction to EI course within six months of the date of employment.

RESPONSIBILITIES: Service Coordination, IFSP Development, and delivery of those services not requiring "qualified personnel." Caseload maximum is 25 after completion of the above continuing education requirements.

SUPERVISION: If no previous experience in EI, works under the mentorship of a Service Coordinator II or a Clinical Supervisor for a period of 6 months. Participates in individual supervision with EI qualified personnel or clinical supervisor a minimum of 1 hour/ week, quarterly assurance studies, and peer review staff meetings.

STARTING SALARY: \$25,174 - \$28,913 based on 40 hours/week

JOB TITLE: Service Coordinator II

QUALIFICATIONS: Bachelor's, Master's, or higher degree consistent with R.I. Early Intervention Personnel Standards for "qualified personnel." Completion of a program of advanced study as required for certification, licensure, or registration in the relevant discipline. Current certificate, license, or registration for an occupation discipline listed as "qualified personnel" in R.I. Early Intervention Personnel Standards.

CONTINUING EDUCATION REQUIREMENTS: As needed to maintain certificate, license, or registration in the relevant disciplines; and training specializing in working with young children with disabilities and their families. Must complete the Introduction to EI course within 6 months of date of employment.

RESPONSIBILITIES: Service coordination, evaluation and assessment, IFSP development, delivery of EI services requiring "qualified personnel," and supervision of preservice students and allied health personnel as directed. Mentors Service Coordinators I and Early Interventionists and has caseload maximum of 20 families for service coordination, if there are evaluation, mentoring, service delivery and/or supervisory responsibilities. Is able to carry out the above responsibilities independently and participates in quality assurance studies, utilization reviews, peer reviews and staff meetings.

SUPERVISION: In conformity with ethical and licensing requirements of the discipline, if appropriate. Directly supervised by early intervention agency administrator, clinical supervisor, or other experienced "qualified personnel" meeting Service Coordinator II criteria.

STARTING SALARY: \$29,932 - \$35,463 based on 40 hours

NEW JOB TITLE: CLINICAL SUPERVISOR

QUALIFICATIONS: Certified or licensed as an independent practitioner consistent with R.I. Early Intervention Personnel Standards, "qualified personnel" categories and a minimum of 3 years working with young children and their families.

CONTINUING EDUCATION REQUIRMENTS: As needed to maintain certificate, license or registration in relevant disciplines and coursework specializing in working with young children with disabilities and their families; and completion of the Introduction to EI course within 6 months of date of employment.

RESPONSIBILTIES: Provides group and individual supervision. Chairs utilization review, quality assurance studies and peer review meetings. These responsibilities do not preclude the possibility of providing direct services, if deemed appropriate by the program.

SUPERVISION: In accordance with employee's annual performance goals.

STARTING SALARY: \$35,000 - \$45,000

XI. TRANSITION AND DISCHARGE

TRANSITION OF CHILDREN TO PRESCHOOL PROGRAMS

All EI sites must adopt a procedure to ensure a smooth transition for children from EI to other environments. Optimally, this process begins with an overview of transition when the child enters the program. Parent education and parent-to-parent support is given regarding the general transition process beginning when the child is approximately 24 months of age. When the child is 28 months old, parent consent to notify the Local Educational Authority (LEA) is sought by the service coordinator and when received is sent to the LEA.

A transition team, comprised of the parent(s), service coordinator, representative from the LEA of the child's residence, and other individuals as requested by the parent, is selected to meet and a meeting is scheduled. Under recommended practice, the first transition meeting occurs when the child reaches thirty months, (6 months prior to the child's third birthday) at the discretion of all parties involved.

These timelines must be adjusted for those children who turn three during the summer months, so that six months of planning time is available to the transition team. EI has the responsibility of convening the 30-month meeting.

Parents should be informed that approximately 2/3 of children receiving EI services are eligible for preschool services. However, it is expected that all parents will be encouraged to participate in a 30-month meeting with an LEA representative who may be able to assist the family if additional developmental concerns arise in the three-to-five year old period and to help explore possible community options with parents. This process was delineated by an interagency work group in the "Steps to Transition" document (See Appendix G).

Emerging from the transition meeting is a written transition plan of activities that will occur in order to maximize continuity of services and prevent disruption of a child's progress. Such written plans must include:

- the type and extent of evaluation data required to determine the child's status and eligibility for preschool programs under Part B services at age three, or referral to other appropriate services, as well as the person(s) responsible for performing the evaluations
- the procedures to prepare the child for changes in service delivery, including steps to help the child adjust and function in a new setting
- the procedures to be used for exploration of appropriate service environments (program options) for the child, including discussion with and training of parents regarding future placement and other matters related to the child's transition at age three
- a review of the child's program options for the period from the child's third birthday through the remainder of the school year

- with parent consent, the procedures for transferring information about the child, including evaluation, assessment, and IFSP information, to the LEA, if the child is judged eligible for special education
- provision of services at thirty-six months from the Local Educational Authority (LEA), to ensure continuity of services
- the procedures for preparing an individualized education plan (IEP), if the child is judged eligible for special education services at thirty-six months
- specific timelines for completing the above activities

To summarize this process, when a child turns thirty months of age, a transition team minimally consisting of an LEA representative, parent, and EI representative convenes to determine the activities to take place during the transition, the timelines in which they will occur, and persons responsible for carrying out these activities. This results in a written Transition Plan.

These events ideally occur over a six-month period of time and reflect the individual needs of the child and participation of the family. In addition to the 30-month transition planning meeting, an eligibility meeting and IEP meeting (for children who are eligible) are held within the six-month period. The LEA is responsible for these meetings, however appropriate EI staff should attend them if the parent wishes them to. For children who will turn thirty-six months between May and September, these events occur on an adjusted timeline that allows for the participation of all three parties and to ensure placement upon the opening of school, or when the child turns thirty-six months, if a 230-day or extended school year program is to be provided to the child.

In the event that the child is judged eligible for a 230-day program or extended school year program by the LEA, such placements, upon parent approval, are initiated no later than the child's third birthday. In the event that the LEA judges the child eligible for a 180-day program, such placements also occur no later than the child's third birthday. In cases where children are judged eligible for services yet turn three between June 1 and September 1, the school district is responsible for determining if any services are needed and providing such services, until the beginning of the school academic year. EI staff will be available to help coordinate such services (i.e., share information about options, provide information to service providers).

The procedures described above have been incorporated into the Regulations of the R.I. Board of Regents for Elementary and Secondary Education Governing the Special Education of Handicapped Children, amended December 2000, Appendix D, as well as the R.I. Rules and Regulations Pertaining to the Provision of EI Services for Infants and Toddlers who are Disabled and Their Families.

It is the expectation by both law and regulation that children in EI will be in a LEA placement, if eligible, on their third birthday. If that does not occur, families can access Part B procedural safeguards. Please also note that EI is not considered the “stay put” when an IEP is under dispute.

All direct services (i.e., group, therapy, etc.) end at the third birthday, unless there are exceptional documented circumstances, the continuation of services is very time limited, and the plan to complete and exit the services are part of the IFSP. In such cases, a special request should be made to HEALTH to authorize such services. This is, in part, so that HEALTH can document the cost of such situations to the EI system, document interdepartmental issues and to insure that the services available to children under three are sufficient.

An example of an authorized request is: an EI PT ordered equipment for a child, the equipment came the day before child's third birthday, HEALTH authorized two post-three years of age visits so the PT could train the family in the use of the equipment. Providers may allow a family to finish a group (i.e. finish out a week) or training that a family began prior to third birthday (i.e. the last two weeks of a 10-week gym program).

In some cases, the LEA may wish to consider "contracting" and paying for continued services through an EI provider for those children who will turn three during the summer. This is permissible as long as the transition team determines it to be appropriate clinically *and* the EI provider has sufficient capacity to provide services to enrolled and referred children under three years old.

TRANSITIONS TO OTHER COMMUNITY PROGRAMS

With the family, EI service coordinators explore community-based options for children who may not be or are found not eligible for preschool services. This may include, with family consent, a conference among the EI staff, the family, the LEA, and providers of other appropriate services for children who are not eligible for preschool services under Part B, to discuss possible service options and the steps needed (if any) to prepare for participation.

Options to be considered may include Head Start, Early Head Start, Parents as Teachers Programs, community programs offered through community centers and libraries as well as private facilities such as child care centers or therapy agencies. These options can also be considered for children who are discharged from EI prior to age three. Face-to-face contact with this array of possible post EI placements is also considered to be transition planning and should be written into the IFSP.

TRANSITIONS TO ANOTHER EI PROVIDER

Family requests to transition to another EI provider must be honored and supported with the utmost professionalism. In fact, when a family is moving from one community to another, it may be beneficial for a family to transition to a full service EI provider in the same community, given the depth of relationships an EI provider is expected to have within that community. Families may, however, wish to receive services outside of their home community for many reasons (i.e., a change in work or child care) and this choice must be honored by all providers as all providers are expected to provide services on a statewide basis. If a family wishes to change

providers due to dissatisfaction with services, it is expected that the family be offered the opportunity to access procedural safeguards as an alternative to changing providers.

Once a family has made a decision to change EI providers, the current EI provider will obtain family's permission to make the referral to the prospective provider, complete the change of provider form with the family, and send the prospective provider a copy of the child's most recent evaluation(s), IFSP, and IFSP review. If the family elects to self-transfer to the prospective provider, the prospective providers should request these documents from the original EI provider. If a family refuses to release such information, the provider may choose to access procedural safeguards (Section XII).

TRANSITIONS FROM OUT-OF-STATE EARLY INTERVENTION PROGRAMS

All EI providers must accept referrals from out of state EI providers or directly from families who are moving to Rhode Island. The EI provider must either complete a multidisciplinary team evaluation or conduct a multidisciplinary review of the most recent evaluation from the referring EI provider to determine the child's eligibility for services under the State of Rhode Island's eligibility criteria. The eligibility determination must be in writing and reviewed with the family.

If a child is not eligible for services in Rhode Island, community referrals, as appropriate, are facilitated. Additionally, families must be informed of their right to due process. If families are eligible for services in Rhode Island, an IFSP review must be held to determine status of goals and delineate needed services.

Providers may not alter the services (if such services are mandated by IDEA) in an out-of-state IFSP on the basis of provider capacity. However as different states have different philosophies of service delivery and service options, goals may be addressed within the RI system of service delivery. If team members (including parents) are not in agreement regarding services, they may access the appeals process described in procedural safeguards.

CONFIDENTIALITY IN TRANSITION

Every effort should be made to obtain written parent permission for the release of any information. In certain circumscribed circumstances regarding Child Find activities (EI to EI, EI to LEA), basic referral information might be shared without written consent if the following criteria are met:

- The family receives written notice that the information is to be shared.
- The family is allowed 10 days to object, before the information is sent.
- If the family objects, the information is not sent. If the EI provider disagrees with family's decision, the provider may access Procedural Safeguards (Section XII).

DISCHARGE FROM EI

Children/families may be discharged from the EI provider for the following reasons:

- The child no longer meets eligibility criteria, as agreed by the multidisciplinary evaluation team, service coordinator, and family. Other referrals have been made as appropriate.
- The child reached age three.
- The child will begin receiving services from the local school system or other community local agency.
- Due to the voluntary nature of the program, a family refuses services.
- A family who has moved out of the state will be discharged. Prior to the move, EI staff will assist in transitioning to a new EI provider, if the family desires.
- A family or child will be discharged after repeated unsuccessful attempts by the EI provider to make contact. This minimally includes telephone and written contacts in the family's native language. In such cases, the referral source will be notified if the EI provider was unable to make initial contact after referral. The pediatrician and other community partners (given appropriate consents) will be informed of the discharge if it occurs after initial contact.
- The child dies.

XII. PROCEDURAL SAFEGUARDS AND CONFIDENTIALITY

As families are viewed as fully collaborating partners in the development of their child's IFSP, including in the determination of goals and services, it is expected that all service decisions are made with families in the context of the IFSP process. It is also expected that the majority of parent questions and concerns will be addressed within the context of a collaborative IFSP process. Thus although not a formal procedural safeguard, IFSP reviews, which may occur at any time they are requested by families or provider staff, may be considered as one avenue available to resolve disagreements in EI.

In addition to the IFSP review process, several safeguards are available to families and EI providers. The intent of procedural safeguards is to ensure that: (1) parents are fully informed of all recommendations being advanced by EIP staff, (2) that parents are allowed the opportunity to inspect and review records, (3) standards to ensure confidentiality of families are in place, (4) recommendations and direct services cannot be initiated or changed without written parental consent, and (5) that in those instances in which disagreement occurs between provider staff and parents regarding the nature of the assessment process or direct service provision, impartial mediation and hearing procedures be available for resolving such issues.

Each of these broad goals encompasses a number of specific parental rights. These are further detailed as follows:

Parents are fully informed of all recommendations being advanced by EIP staff, and parents are allowed the opportunity to inspect and review records:

Opportunity to Examine Records: The parent(s) of eligible children must be afforded the opportunity to inspect and review all records regarding their child, including those relating to evaluation and assessment, eligibility determination, development and implementation of IFSPs, individual complaints dealing with the child, and any other area involving records about the child and family. Parents must be informed in their native language of the nature, type, and purpose of information contained within records, and must receive written notice of a provider's policies and procedures regarding information collection, storage, disclosure, and destruction. (See Appendix J for Sample).

Access Rights: Requests for record reviews by parents must be complied with promptly and in no case exceed forty-five days. Record reviews must be facilitated, upon request, prior to IFSP meetings, hearings related to the child's identification, evaluation, or placement or provision of EIS and at any time within the identification, evaluation, and program planning process. Parents or their designated representative may also request copies of records containing information if failure to provide that information would effectively prevent the parent from the right to inspect and review records.

Parents or their representatives have the right to a response to reasonable requests for explanations and interpretations of records. HEALTH and EI providers will presume the parent has the authority to inspect and review his/her child's records unless advised that the parent does not have that authority under State law governing guardianship, separation and divorce. In those

cases, where parent access to the record is limited, documentation of such limitations (i.e., court orders) should be maintained in the child's record.

Amendment of Record at Parent's Request: In those instances in which the parent believes that the record is inaccurate, misleading, or violates the privacy or rights of the child or family, the parent may request the agency to amend the information. Such amendments, if agreed to by the agencies, must occur promptly. The agency may, within a reasonable time, decide whether to amend the record. If an agency refuses to amend the record, the parent is notified in writing and is informed of their right to an impartial hearing (see Impartial Hearing Section for more information). In either case the agency must note in the record the parents expressed disagreement with the information.

List of Types and Locations of Information: EI providers must provide parents, upon request, a list of the types and location of records collected, maintained, or used by the agency in the native language of the parents.

Fees: EI providers in Rhode Island may *not* charge fees to search for or retrieve information or for copies of records.

Prior Notice in Native Language: Written notice must be given to the parent(s) of child prior to the provision or modification of EIS to the child or family. In general, written notice and parent consent is provided for through the IFSP/IFSP review process. However, in those cases in which parent consent is not obtained at the ISFP or IFSP review, then written notice must be provided to the parent within a reasonable time before the agency proposes or refuses to initiate or change the identification, evaluation, or placement of a child or provide EIS. If the parent is deaf or blind, or has no written language, the notice must be in the language or mode of communication normally used by the parent.

This notice must be in sufficient detail to inform the parent(s) about the action being proposed or refused, must include the reasons for the actions proposed, and must include all procedural safeguards.

Standards to ensure confidentiality:

EI providers must adopt policies and procedures in order to ensure the protection of any personally identifiable information collected, used, or maintained. This includes the right of parents or guardians to written notice of and written consent to the exchange of this information. These policies and procedures must be consistent with federal and state law.

Consent: Written parental consent must be obtained before personally identifiable information is disclosed to any individual not affiliated with the agency (other than employee, volunteer, contracted service provider {with a signed contract, RIPIN parent consultants fall in this category}), or to any other agency, or for any other purpose than to comply with the IFSP. The agency may not release information from the records to participating agencies without the consent of the parent unless authorized to do so under the Family Education Rights and Privacy

Act (FERPA). FERPA does allow for the release of limited information, without parent consent, between educational agencies for Child Find purposes under certain prescribed circumstances (see Confidentiality in Transition for more information regarding these circumstances).

In the event that the child's multidisciplinary or IFSP team believes failure to release information would be harmful to the health or welfare of the child, the agency may request a due process hearing to determine if the information may be released without parental consent. Additionally, cases of suspected abuse or neglect must be reported to DCYF, as EI employees are considered to be mandated reporters.

Externally generated reports, such as evaluation reports, can not be released to another agency (including another EI provider or LEA), unless EI paid for such reports. It is recommended that EI providers note that reports paid for by EI will be released as part of the EI record in contracts with providers of such evaluations and services. An IFSP completed by one EI provider and used by another EI provider as the basis for providing services is not considered an externally generated report and may, with the family's permission, be released to another agency.

Record of Access: All participating agencies which maintain confidential or personally identifiable information on children and their families must keep a record of parties obtaining access to those records collected, maintained, or used (except access by parents and authorized employees of the agency), including: (1) the name of the party requesting access, (2) the date of access, and (3) the purpose for which the party is authorized to use the records.

Records On More Than One Child: If any record includes information on more than one child, parents of those children have the right to inspect and review only the information relating to their child or to be informed of that specific information.

Destruction of Information: Permanent record information (including name, address, phone number, and attendance) may be maintained without time limitation. Other information must be destroyed if the parent so requests. The agency must inform the parent when personally identifiable information is no longer needed to provide services and that the child's record is scheduled for destruction.

As EI is considered to be an educational program, records must be maintained to the standard of all other educational records. Thus EI child records are expected to be maintained for a minimum of seven years after the child's discharge date unless the parent requests the destruction of the record. However, EI providers are also expected to maintain the standards for record maintenance of all payers of the services listed on the IFSP. The most conservative standard is typically five years after the child reaches age of majority. It is strongly recommended that all EI providers consider implementing this standard, given the range of EI payers and the mobility of many EI families.

Storage of Records: All records that contain personally identifiable information, including those of both active and inactive children, must be kept in a secure location. File cabinets and or file rooms must be locked and a procedure for accessing records must be in place.

Enforcement: HEALTH has developed policies and procedures, including sanctions, to ensure that the confidentiality requirements are followed.

Each service provider, agency, institution, and organization that provides services under Part C participates in a self-review process, as well as monitoring and on-site reviews by HEALTH to ensure that all policies and procedures are being followed.

Sanctions for failure to comply with the Part C requirements identified during the monitoring process and including correction of identified deficiencies may include the withholding of Part C funds and/or revocation of certification status if determined appropriate by HEALTH, in consultation with the ICC.

If HEALTH or its authorized representatives collect any personally identifiable information regarding children with disabilities which is not subject to the Privacy Act of 1974, the Agency Director will apply the requirement of the Statute 5USC522A, the Privacy Act of 1974, and regulations implementing those provisions.

Recommendations and direct services cannot be initiated or changed without written parental consent:

Parent Consent: Written parental consent must be obtained before conducting the initial and annual evaluation and assessments and initiating the provision of EIS. If consent is not given by the parent, the EI provider makes reasonable efforts to ensure that the parent is fully aware of the nature of the evaluation and assessment or services that would be available and understands that the child will not be able to receive the evaluation and assessment or services unless consent is given.

If a parent refuses the evaluation and assessment for a child who is eligible for EI (by established condition or by previously determined eligibility or for whom probable eligibility is known), the provider may request a hearing through HEALTH. Additionally, providers must consider this refusal under their obligation as mandated reporters of child abuse and neglect.

Parent Rights to Decline Service: Parents of an eligible child may determine whether they, their child, or other family members will accept or decline any EI service under Part C in accordance with state law. Parents may decline any such service (this does not include eligibility evaluation and assessment, IFSP development or service coordination to complete evaluation, assessment, and IFSP requirements) at any time without jeopardizing other EI services. If a parent refuses services for a child who is eligible for EI, the provider may request a hearing through HEALTH. Additionally, providers must consider this refusal under their obligation as mandated reporters of child abuse and neglect (i.e., whether the lack of service would meet DCYF criteria for abuse or neglect).

In those instances in which disagreement occurs between provider staff and parents regarding the nature of the assessment process or direct service provision, impartial mediation and hearing procedures are available for resolving such issues.

In general, it is recommended that issues and concerns be addressed at the most informal level whenever possible. Thus, when possible, concerns should be raised first between a service coordinator and family, then a program director and family. Next steps would include mediation and formal due process.

It is important to note that families can request informal confidential technical assistance through the Client Services Coordinator at HEALTH or through the Parent Consultant Program at any time. Families are under no obligation to follow these recommended procedures sequentially. They can access any of these steps to resolution of issues at any time.

Additionally, if a family has reason to believe that they have not received EI services as outlined in federal and state law, they may file a formal complaint through the Policy Coordinator at HEALTH. Examples of circumstances in which a formal complaint may be filed include but are not limited to: services not being provided as delineated in the IFSP, incomplete IFSP after 45 days of referral, and failure of a provider to honor a family request for an IFSP review.

Upon conclusion of an investigation, HEALTH may order that an EI provider take a specified action to ensure that a family receives EI as indicated by law. Alternatively or in addition, families may access all other procedural safeguards to resolve a formal complaint.

MEDIATION PROCEDURE

Mediation is a form of conflict resolution in which an impartial "mediator" is called upon to attempt to reach a resolution of differences of opinion between parent (s) and EIS providers. Mediation is both an informal and flexible process designed to reach agreement between parties. Either party to a disagreement may submit a written or verbal request to HEALTH for mediation. Requests for mediation should be made to either the Client Services Coordinator or the Policy Coordinator. The Policy Coordinator maintains the written records of mediation and will appoint a mediator within two weeks (14 calendar days) of receiving a request for mediation.

HEALTH maintains a list of individuals who are qualified mediators and knowledgeable in laws and regulations relating to the provision of EI services. HEALTH bears the cost of the mediation process. Each session in the mediation process is scheduled in a timely manner and is held in a location that is convenient to the parties to the dispute. Generally, in addition to parents, a person from the EI program who has a relationship with the family and a provider representative who has decision-making ability will be present for the mediation meeting. All other members of the family's team are expected to be available, if needed.

An agreement reached by the parties to the dispute in the mediation process is set forth in a written mediation agreement. Discussions that occur during the mediation process are confidential and may not be used as evidence in any subsequent due process hearings or civil

proceedings, and the parties to the mediation process are required to sign a confidentiality pledge prior to the commencement of such process.

HEALTH ensures that the mediation process:

- is voluntary on the part of the parties,
- is not used to deny or delay a parent's right to a due process hearing or to deny any other parental rights afforded under Part C, and
- is conducted by a qualified and impartial mediator who is trained in effective mediation techniques.

IMPARTIAL DUE PROCESS HEARING

A parent or public agency may initiate a hearing on any matter pertaining to prior written notice related to the public agency's proposal or refusal to initiate or change the identification, evaluation, or the provision of services to a child. The procedures of 34 CFR sections 300.507 - 300.512, Part B of IDEA, have been adopted. At the conclusion of the hearing, HEALTH, after deleting any personally identifying information, transmits the findings to the ICC and makes the findings and decisions available to the public.

Hearings Initiated by the Parent(s): A hearing may be initiated by the parent(s) by filing a written complaint with HEALTH and/or the administrator of the EI provider. HEALTH provides a form to the parents or the parents' attorney to assist them in filing a request for due process. The information on this form includes:

- the name of the child,
- the address of the residence of the child and the name of the EI provider where the child is enrolled, if appropriate,
- a description of the nature of the problem of the child relating to the proposed initiation or change, including facts relating to the problem, and
- a proposed resolution of the problem to the extent known and available to the parents at the time.

HEALTH must inform the parent of any free or low-cost legal and other relevant services available in the area if the parent requests the information or the agency initiates a hearing. Within ten days after a request, a hearing officer must be designated.

Hearings Initiated by the EI Provider: The administrator of an EI provider may initiate a hearing by written notice to HEALTH with a copy of the notice mailed to the parent(s). Within ten days, a hearing officer must be designated.

HEALTH will inform the parent(s) of any free or low-cost legal and other relevant services available in the area. A form is sent to the parents with information relating to legal counsel.

Impartial Hearing Officer: The hearing officer must not be an employee of a public agency involved in the education or care of the child, or be a person who has any personal or professional interest interfering with objectivity in the hearing. A person who qualifies as a hearing officer is not disqualified solely because he/she is paid by the public agency to implement the complaint resolution process.

The hearing officer must have knowledge about the provision of complaint management requirements, the needs of the child/family, and services available to the child/ family. It is the responsibility of HEALTH to assign and financially reimburse the hearing officer. HEALTH keeps a list of persons who serve as hearing officers, which includes the qualifications of each of those persons.

Hearing Rights: Any party to an impartial due process hearing has the right to:

- have each due process hearing and each review conducted at a time and place that is reasonably convenient to the parents, if oral arguments are involved. The final decision will be reached and a written decision will be mailed to each party not later than 30 days after receipt of a request for a hearing. A hearing officer may grant specific extensions of timelines beyond the 30-day period at the request of either party
- be accompanied and advised by counsel and by individuals with special knowledge or training with respect to the problems of children with disabilities
- present evidence and confront, cross-examine, and compel the attendance of witnesses
- prohibit the introduction of any evidence at the hearing that has not been disclosed to the other party at least five days before the hearing
- obtain a written, or, at the option of the parents, electronic verbatim record of the hearing
- obtain written, or, at the option of the parents, electronic findings of fact and decisions
- at least five business days prior to the hearing have disclosure by each to all other parties of all evaluations completed by that date and recommendations based on the offering party's evaluations that the party intends to use at the hearing
- have a hearing officer bar any party that fails to comply with the preceding paragraph from introducing the relevant evaluation or recommendation at the hearing without the consent of the other party

Parents involved in a hearing have the right to have the child who is the subject of the hearing present and to open the hearing to the public.

A decision made in an impartial due process hearing is final unless a party to the hearing appeals this decision.

Administrative Appeal - Impartial Review: If the hearing is conducted by a public agency other than the lead agency, any party aggrieved by the decision may appeal to the lead agency, HEALTH. If there is an appeal, the lead agency conducts an impartial review of the hearing. A review officer conducts an impartial review of the hearing. The official conducting the review:

- examines the entire hearing record
- ensures that the procedures at the hearing were consistent with the requirements of due process
- seeks additional evidence, if necessary, applying all rights previously cited
- affords the parties an opportunity for oral or written argument, or both, at the discretion of the reviewing official
- makes an independent decision on completion of the review, no later than 30 days after the request for the review. A reviewing officer may grant specific extensions of timelines beyond the 30-day period at the request of either party.
- gives or mails a copy of the written findings and the decision to the parties

The lead agency, after deleting any personally identifiable information, transmits the findings and decision of the review to the ICC and makes the findings and decision available to the public.

The decision made by the reviewing official is final, unless a party brings civil action in a State or Federal court.

Civil Action: Any party aggrieved by the decision of the reviewing officer has the right to bring civil action.

Child's Status During the Proceedings: During the pendency of any administrative or judicial proceeding regarding a complaint, unless the EI provider and parent(s) of the child agree otherwise, the child involved must continue to receive EI services as delineated in the most recent IFSP that the parent has consented to. If the complaint involves an application for initial services, the child must receive those services not in dispute.

Opportunity for a Hearing Regarding Information Contained Within Records: Parents are entitled to an impartial hearing if they believe that the contents of their child's record are inaccurate, misleading, or violate the privacy or rights of the child or family.

If the impartial hearing finds that the record is inaccurate, misleading, or in violation of privacy or other rights of the child, the agency must amend the record and so inform the parents of such amendments, in writing, within one week of the decision.

If the impartial hearing finds that the record is accurate, not misleading, or not in violation of privacy or other rights of the child, the agency must inform the parents of their right to insert a written statement into the record, commenting on information or expressing disagreement with the decision of the agency. Such statements must be maintained as part of the child's record, as long as the child's record or contested portion is maintained by the agency, and must be disclosed if the record or the contested part is reviewed by any party.

Hearing Procedures: Any hearing held under this part must be conducted under the procedures in 34 CFR 99, the Family Education Rights and Privacy Act (FERPA).

Surrogate Parent Program: In accordance with federal regulation, HEALTH has established this program to ensure that the interest of children in DCYF custody are being appropriately served.

When a child involved with DCYF is referred to EI, the provider must determine whether a surrogate parent will need to be assigned. Simply stated, there are three options:

1. If the child's placement with DCYF is voluntary *or* if DCYF has temporary or permanent custody on a dependency, neglect or abuse petition and *the child is at home*, then the parent retains rights to make EI decisions and no surrogate parent is assigned. However, if a parent fails to participate in decision making s/he will be asked to sign a waiver which indicates that the parent waives his/her right to make EI decisions for the child, and a surrogate parent will be assigned.
2. If parental rights have been terminated, the power to make educational decisions for the child has been vested in DCYF by the courts, or no person acting as a parent (such as grandparent or stepparent with whom the child lives, or a person who is legally responsible for the child's welfare {IDEA, sec 303.19}) can be determined, then a surrogate parent will be assigned. In those instances where a Termination of Parent Rights (TPR) has been filed by DCYF but is not finalized by the court, the biological parent(s) are considered to retain the right to represent their child in EI, unless the power to make educational decisions has been vested in DCYF by the courts.
3. If parental rights have *not* been terminated and *the child is placed outside of the home*, then HEALTH will attempt to contact the parent to inform them of child's referral to EI and their right to act as advocate for their child. The parent is asked to contact HEALTH within ten days, or a surrogate parent will be appointed for the child.

Most children who are wards of the state are eventually returned home. When the plan is to return the child home, the birth parent, if at all feasible, should retain his/her involvement and continue to act as the advocate for the child. A good working relationship between the EI service providers and the parent will increase the likelihood that the parent will maintain their child's participation in EI and will be able to follow through with developmental interventions that have been recommended.

Informing and involving the DCYF worker is also an important aspect of developing and implementing a plan which supports the parent while the child is in placement as well as during their transition back to their home.

Even if a surrogate parent is appointed, the EI service coordinator and the DCYF caseworker should work with the biological parent on a plan for the biological parent's participation, unless a TPR has occurred or is anticipated in order to contribute to a successful reunification. The detailed procedure for follow-up on a referral for a family who is involved with DCYF is available in Appendix H.

Once it is determined that a surrogate parent needs to be appointed, several factors must be considered. A surrogate parent must meet certain criteria. These include:

- No conflict of interest with child
- Has knowledge and skills that ensure adequate representation of the child
- Closeness of relationship to child – The person serving to represent the child in EI should be the person most closely tied to the child. The following is a list of people in order of preference who may potentially represent a child in EI: Birth parent, person acting as parent, interested relative, foster parent (birth parent may object unless a TPR has occurred or the court has vested educational decision making with DCYF), friend to the child's family, stranger to the child's family

The surrogate parent represents the children in:

- Evaluation and Assessment
- Development of the IFSP
- EI Services
- Any other rights under Part C

Surrogate parents should also know:

- HEALTH is the decision maker and can appoint and unappoint a surrogate parent (i.e., if a child goes home).
- The surrogate parent has to sign his/her name on some EI documents (consents and IFSP), and the birth parent may have access to the records.
- Surrogate parents have rights only as they pertain to EI educational decisions.
- It is important to ask the surrogate parent that he/she consider continuing as the educational advocate after the child turns age three, unless the status of the birth parent changes.

Surrogate parents are appointed on a temporary basis. This appointment is official once the surrogate parent completes the surrogate parent training. The purpose of the training is to ensure

that the appointed surrogate parent has the skills and knowledge to ensure adequate representation of the child. This training should occur within 30 days of the temporary appointment. Surrogate parents will be trained by the parent consultant of the provider to which the referral was made. If no parent consultant is currently available to a provider, RIPIN will assign another parent consultant to provide the training. Although not required, the service coordinator is strongly encouraged to attend the training session for the surrogate parent and be available for questions.

The Surrogate Parent Coordinator at HEALTH will provide the parent consultant with the name and contact information for the identified surrogate parent so that the required training can be coordinated. If no parent consultant is available, then the Surrogate Parent Coordinator will contact RIPIN to assign another parent consultant. The parent consultant will inform the service coordinator that the name of the surrogate parent has been received and will schedule the training with the surrogate parent and the service coordinator. The training will consist of a presentation of the rights that all parents (including surrogate parents) have in EI and an overview of Procedural Safeguards.

Additionally, the Surrogate Parent Agreement will be reviewed and signed by the surrogate parent. The surrogate parent will be provided with the Surrogate Parent Coordinator's card/contact information. The signed Surrogate Parent Agreement will be returned to the Surrogate Parent Coordinator, who will then send a certificate of completion of training to the surrogate parent. A copy of the Surrogate Parent Agreement should be maintained in the child's program file and given to the surrogate parent.

Once trained, a surrogate parent may be appointed as the surrogate parent to other children without additional training upon completion of the Surrogate Parent Agreement, unless HEALTH determines that the training provided has been subsequently revised.

XIII. PROGRAM ADMINISTRATION

EI providers must have sufficient capability to carry out the various operational functions necessary to provide EIS. In addition to the capacity to provide direct EI services, providers must demonstrate capacity in related areas. Related areas include capacity (1) to manage ongoing operations, (2) to coordinate effectively with community agencies, (3) to maintain positive partnerships with other EI providers, (4) to supervise staff so that appropriately trained and qualified staff develop appropriate relationships with families and engage in appropriate service delivery, and (5) to utilize the results of HEALTH's Quality Assurance Procedures and agency specific quality assurance activities to improve services to children and families. Specifically this includes:

CAPACITY TO MANAGE ONGOING OPERATIONS

It is necessary for providers to be fully integrated into the EI fee-for-service reimbursement system. This includes the demonstration of capacity for timely billing for services to HEALTH. Providers must follow all guidelines in the HEALTH issued Reimbursement Guide. While the costs of providing high quality, effective EIS may vary, depending on the needs of the individual child, all children enrolled in EI will receive the highest quality of services in appropriate frequency, scope, and duration.

The EI provider must maintain appropriate and necessary staff capacity to assure timely fiscal management that maximizes collection of funds from available sources such as Medicaid, private insurers, categorical grants, and state funds. Policies, procedures, and experience in third-party billing and coordination of benefits in relation to Medicaid must be demonstrated. EI providers must assure that such billing practices adhere to recognized best accounting practices.

Services to which an eligible infant or toddler is entitled under any other Federal, State, private, and local sources are not paid for with Part C funds. That is, Part C funds and allocated State funds for EI are utilized last after all other funding sources have been adequately pursued.

Providers must demonstrate methods for determining future cash requirements and plans for ensuring adequate cash flow.

Providers must demonstrate risk management arrangements, with specific attention to general liability, professional liability, and directors' and officers' liability.

The provision of an annual certified audit as prescribed by HEALTH is assured.

Providers must maintain the staff and systems required to support the EI Management Information System (EIMIS). Providers must enter all required data into EIMIS and provide that data to HEALTH on a monthly basis or as requested by HEALTH.

The EI provider must notify HEALTH monthly of staffing changes.

CAPACITY TO COORDINATE EFFECTIVELY WITH COMMUNITY AGENCIES

HEALTH's view of effective community collaboration extends to building and utilizing a community support network for young children and their families. EI is one link in such a network. Other links include Family Outreach Programs/VNA, primary care physicians, WIC, Department of Human Services Programs, Head Start/Early Head Start Programs, local school departments, and local child care centers.

At a minimum, EI providers must be able to demonstrate receiving and/or making referrals to other links. Those children who are evaluated by EI but are not eligible for EI services will be referred to appropriate programs that will benefit the child, such as Early Head Start, etc., given family consent. Unmet needs of the population of children not eligible for EI will be documented and submitted to HEALTH and by HEALTH to the Interagency Coordinating Council (ICC).

When any other linking agency or program is listed in a child's IFSP, the EI provider is responsible for demonstrating at minimum service coordination with that agency or program, given family consent. Other services, such as consult to agency, may also be appropriate when included in the IFSP.

Each community has unique programs and supports available to its members. Such programs and supports may be available through libraries (children's programs, passes to the zoo), churches, community centers, local social service agencies, hospitals, etc. It is the responsibility of EI providers to develop knowledge of such community supports and facilitate families in accessing them, with family consent.

If a child is placed in a community setting in order to meet an IFSP goal, then the means by which EI will provide support to that setting must be delineated in a Memorandum of Agreement (MOA) that is developed between EI and the community setting. In accordance with standards for billing available in HEALTH's Reimbursement Guide, this support must include the provision of two units of service coordination per month at minimum.

Building community networks often involves interacting with other community agencies or organizations around community issues, ideas or projects that are not directly related to an individual child and thus are not directly billable to HEALTH. As participation in such interactions ultimately benefits children and their families, EI providers have a responsibility, both by best practice and by contract (through the Certification Standards), to engage in community activities.

EI providers are expected to attend Community Partnership meetings organized by HEALTH with the specific purpose of facilitating coordination between HEALTH programs that provide services to young children and their families. Additionally, the requirement for community participation may be met by participation in collaborative workgroups, such as the Durable Medical Equipment group, the Very Low Birthweight group, the Summer Institute (if an EI relevant topic), the Community Collaboration Project, etc.

In addition, EI providers are strongly encouraged to offer their expertise to other community programs in order to build relationships and enhance the array of services available to all young children. This may be done through presentations to local child care settings, collaboration in a play group with a local Parents as Teachers Program, serving on a Board for Head Start, as outreach to a local parent group, etc. Participation in all community activities must be documented and available for HEALTH review (see sample form in Appendix K).

Although HEALTH has not yet determined a minimum standard for community participation, review of community participation will be considered as a key factor in the recertification progress.

CAPACITY TO MAINTAIN POSITIVE PARTNERSHIPS WITH OTHER EI PROVIDERS

Full Service to Full Service Providers: Families should see EI as a system of service delivery as opposed to several different programs. It is for this reason that all full service EI providers are required to be able to access all required services on behalf of their families. Families must be made aware at the time of referral or intake that they have a choice of EI providers; however, no full service provider can refuse a referral from a family that has selected them.

Please see Section XI for information, including confidentiality in transition, regarding transferring a family from one EI provider to another.

Please see the Shared Billing section of the Reimbursement Packet for information on providing services to a child whose Primary Service Coordination agency is another EI provider.

Full Service and Specialty Providers: Any full service provider can make a referral to any specialty provider, given parent consent. To make a referral, a signed release of information should be signed by the parent. The child's evaluation and IFSP should accompany the referral.

- To make a referral to the Family Guidance Program at the School for the Deaf, contact the Program Coordinator at 222-4013.
- To make a referral to the EI Vision or Mobility Specialist, contact the Supervisor of the R.I. Services for the Blind and Visually Impaired at 222-2300, extension 423.
- To make a referral to the Groden Center, contact the Program Director at 274-6130, extension 1006.

Once the referral has been received, the child's service coordinator and a service provider from the specialty program must schedule a co-visit with the family to review the goals that the specialty program will be assisting with and update/review the IFSP goals accordingly.

If a referral is made to a specialty provider directly, it is expected that the specialty provider will obtain parent permission to make a referral to a full service EI provider immediately.

Subsequently, the EI service coordinator will notify and attempt to coordinate the scheduling of all EI evaluations, IFSP meetings, and transition meetings with the specialty provider. This is particularly important in those cases where the expertise of the specialty provider is needed to obtain an appropriate evaluation and assessment and determine appropriate goals. When a specialty provider participates in an evaluation and assessment, he/she may be considered part of the evaluation team and be considered the second required evaluator, as long as that specialty provider meets the definition of qualified personnel and the two evaluators represent two different disciplines (in this case, the full service EI provider should only bill for the staff they contributed to the evaluation).

The specialty providers should also be notified of and attend IFSP reviews. The specialty provider should be provided with a copy of all EI generated evaluation/assessment, IFSPs, IFSP reviews and updates, and transition plans. Upon request, the full service EI provider should provide the specialty provider with any other information in the EI file, including service rendered forms, given parent consent.

Specialty providers must complete Service Rendered Forms for each EI service provided. Copies of completed service rendered forms must be provided to the full service agency at the conclusion of each month. The full service EI provider must enter these services rendered forms into EIMIS using the prepaid service code and file them in the child's chart. At minimum, a co-visit or service coordinator contact is expected to occur with the full service EI provider and the specialty provider on a monthly basis.

In some cases a family may choose to decline EI services other than those offered through the specialty provider. In those cases the specialty provider will assume responsibility for service coordination, including IFSP development, review, and transition at age three. In such cases, a member of the full service EI provider staff may be asked to participate in the evaluation and assessment process to ensure that the requirements for an evaluation and assessment are met.

If the requirements for an evaluation and assessment cannot be met due to a refusal to give consent, then EI services may not be able to be provided (see Section XII for more information). Additionally, if families have declined services from either the specialty or full service provider, then the service coordinator should periodically re-offer the declined services at IFSP, IFSP review, or when otherwise appropriate, given child and family goals.

Interaction with other EI Supports: The Rhode Island Parent Information Network (RIPIN) is the organization that is responsible for the Parent Consultant Program. In accordance with the EI Certification Standards, EI providers must have a Parent Consultant on staff that is hired, trained, supervised and supported financially by RIPIN. EI providers must have a MOA with RIPIN outlining the partnership, as well as the confidentiality agreement.

Parent Consultants are family members who participated in the EI Program, giving them first hand experience in the program and the transition process. Parent Consultants are available to provide individual support to families and staff, facilitate trainings and workshops for families and staff, participate in statewide activities (Comprehensive System of Personnel Development {CSPD}, Transition Advisory Council, Durable Medical Equipment {DME} committee, etc.), as

well as participate in systems change initiatives and policy development. Parent Consultants work with all EI staff to ensure family centered practices and with HEALTH staff in quality assurance efforts (record review, surveying families for satisfaction, etc). For more information, contact RIPIN at 727-4144.

The Early Intervention Training Center: The EI Training Center is responsible for coordinating statewide training for the EI system, including coordinating and/or providing training required by HEALTH. Therefore, EI providers are expected to collaborate with the EI Training Center in assessing the training needs of the EI system and, as appropriate, collaborate in the development and implementation of needed training. EI providers must support training efforts by the participation of their staff in appropriate topical trainings. All EI providers are required to participate in CSPD, which serves as one venue of facilitating this collaboration.

In addition, the EI Training Center will provide technical assistance and support in developing Provider Professional Development Plans, with the goal that such Provider Professional Development Plans be coordinated with Individual Professional Development Plans for staff. The EI Training Center will also be responsible for convening and facilitating the connections to Institutes of Higher Education (IHE), as well as disseminating information regarding best practices. Special Projects which may be coordinated through The EI Training Center include the validation of EI competencies and the exploration of an EI certification process for individual practitioners. For more information, contact the EI Training Center at 277-5409.

Early Childhood Transition Coordinator: The role of the Early Childhood Transition Coordinator is to examine transition from a cross-systems perspective. Based on information gathered, the Early Childhood Transition Coordinator will make recommendations for system changes. EI providers are expected to collaborate with the Early Childhood Transition Coordinator in gathering information regarding transition.

Additionally, EI providers engage solution-based dialogues with LEAs, HEALTH, and RIDE, as facilitated by the Early Childhood Transition Coordinator. The Early Childhood Transition Coordinator can, along with the Parent Consultant agency, also provide programs with information regarding the transition process, and, when needed, contacts within RIDE.

In general, it is recommended that specific parent requests for support during Transition be referred to the Parent Consultant Agency. For more information, contact RIPIN at 727-4144 or the Early Childhood Transition Coordinator at 456-4735.

The Vulnerable Infants Program (VIP): This program for infants who have had prenatal drug exposure is available to children who are in EI programs. In many cases, VIP will be involved with babies and families at the birthing hospital and may make the referral to EI.

With parent consent, VIP can continue to support families after they leave the hospital. If the parent wishes VIP involvement, providers must minimally coordinate services with VIP. VIP can, with parent consent, assist EI providers in the evaluation, IFSP development, and service provision for these infants and their families.

EI providers may also request consultation in working with infants who have had prenatal drug exposure and their families. For more information, contact the VIP EI Liaison at 453-7960, Extension 152.

HEALTH Staff: HEALTH staff are available to EI providers and parents. In general, questions regarding:

- Billing and Reimbursement should be directed to the Billing and Reimbursement Specialist at 222-5926
- EIMIS and Quality Assurance Reports should be directed to the Quality Assurance Coordinator at 222-5956
- Regulation, Policy, Surrogate Parent Program, or Mediation and Due Process should be directed to the Policy Coordinator at 222- 5940
- The ICC and Special Events or Projects should be directed to the Special Projects Coordinator at 222-5941
- Individual Families or Training should be directed to the EI Client Services Coordinator at 222-4625
- The WIC Program should be directed to the WIC Client Services Coordinator at 222-4623
- The Family Outreach Program (FOP) should be directed to the Program Coordinator at 222-4606
- The Lead Program should be directed to the Lead Program Coordinator at 222-4602
- Immunizations should be directed to the Immunization Coordinator at 222-5925

Capacity to train and supervise staff so that appropriately trained and qualified staff develop appropriate relationships with families and engage in appropriate service delivery:

HEALTH, in collaboration with its partners, provides a system of education and training to assure qualified EI staff throughout the EI system. EI providers assure participation of their staff at appropriate education and training events in order to assure their staff meets professional standards. Currently, all staff must attend the Orientation to EI (HDF 298), unless they are certified as EI Specialists in Massachusetts. A copy of that certification must be maintained by the provider and available for HEALTH review. Additionally, EI providers must send a representative with decision making ability to CSPD meetings to provide input regarding the direction of the EI Training System.

EI providers are responsible for reviewing the professional personnel standards, credentials, and for the supervision of their staff, regardless of the amount of direct financial support available for

training and supervision available through HEALTH. The expectations for supervision are noted in Appendix D of the Certification Standards. This Appendix states that Early Interventionists should have individual supervision at a minimum of two hours per week, and Service Coordinators I should have a minimum of one hour per week of supervision with a person meeting the definition of Service Coordinator II. It is also noted that Service Coordinators II are expected to have ongoing supervision with a person meeting the definition of Service Coordinator II/Clinical Supervisor.

The goal of EI supervision focuses on understanding transdisciplinary, family centered practice that is consistent with the requirements of Part C. This includes ensuring that all staff “understand the basic components of the EI system,” are able to “meet the interrelated psychosocial, developmental, and educational needs of eligible children,” and “assist families to learn how to enhance the development of their children and to participate fully in the development of IFSPs.” (Certification Standards, p. 17)

Supervision must also enhance the skills of staff in the ongoing assessment of the child and family within their natural environment. NECTAS, OSEP’s national technical assistance agency, underlines the importance of supervision by stating, “States must ensure that, no matter who acts as their service coordinator, a family experiences the type of family-centered services, rights, and safeguards that are in compliance with Part C of IDEA.”

As service coordinators work across agencies and in communities, supervision and other support strategies (our emphasis)... are extremely important. (Part C Updates, 1998) In summary and in accordance with the Certification Standards, supervision is expected to occur regularly on an individual basis. It should always promote and reinforce “best practice” in EI. Supervision that meets these criteria *must* be done and documented, whether or not providers choose to request the HEALTH reimbursement for supervision.

Based on research that demonstrates the importance of supervision in terms of both quality of services to families and retention of staff (another indicator of quality), HEALTH has committed to supporting supervision on a trial basis through the HEALTH reimbursement for supervision.

Zero to Three, a nationally recognized resource for EI, defined the key features of effective supervision as follows, “Reflection, collaboration, and regularity are essential features of effective supervision...In contrast to casual ‘support,’ supervision and mentorship offer ongoing opportunities to recognize, understand, and cope successfully with the challenges of becoming an infant/family practitioner.”

One goal of the clinical supervisors’ course is to explore the operationalization of effective supervision within programs. It is HEALTH’s expectation that supervision that is submitted for reimbursement will reflect these standards of practice for effective supervision (which encompasses the recommendations of NECTAS and the requirements of the Certification Standards). Supervision, as defined above, does *not*:

- Occur on a group basis, including staff meetings
- Cover agency operation or billing practices

- Cover personnel/disciplinary actions
- Cover short, unscheduled conversations between clinical supervisors and staff
- Cover supervision needed to maintain certificate, license, or registration that is relevant to specialties

For further information regarding the reimbursement of supervision, including required attendance at the supervisors course, please refer to the HEALTH reimbursement guide.

HEALTH further assumes that all providers maintain the highest entry level of licensure, certification, or registration that is the specific requirement of each professional specialty in order to be in compliance with the definition of “qualified” professional and to bill appropriately for service provided.

Capacity to utilize the results of HEALTH’s Quality Assurance Procedures and agency specific quality assurance activities to improve services to children and families:

EI providers must review and, on request, respond to all Quality Assurance Reports generated by HEALTH (see Quality Assurance Procedures documentation for more information).

EI providers must correct deficiencies/areas of noncompliance identified through Quality Assurance Procedures. If deficiencies/areas of noncompliance persist, HEALTH may request a Corrective Action Plan from a provider to address deficiencies/areas of noncompliance. HEALTH may require that specific elements be included in a Corrective Action Plan (i.e., training on confidentiality).

The failure to develop or complete a Corrective Action Plan, once requested by HEALTH, may result in the withholding of funds or changing the certification status of the Provider. Technical Assistance from HEALTH, the Parent Consultant agency, and the EI training partnership will be available to support the agency in the successful completion of a Corrective Action Plan, when appropriate.

EI providers must demonstrate how they will utilize the HEALTH quality assurance information and/or self-generated quality assurance results to set and measure goals for improvement. Technical Assistance from HEALTH, the Parent Consultant agency (RIPIN), and the EI training partnership will be available to support agency goals.

EI providers must use evaluation data regarding the transition process to improve the efficacy of the transition process, with assistance from the Early Childhood Transition Coordinator, when needed.

XIV. HEALTH AND SAFETY

Each EI provider is responsible for developing policies and procedures that support the health and safety of staff, children, and their families. Specifically, this means that providers must (1) develop health care policies (2) develop staff requirements regarding health and safety, (3) develop policies and procedures to ensure staff safety, and (4) develop policies and procedures to ensure safety during center-based activities.

The recommended policies and practices that should be instituted in group settings to prevent disease, injury, and environmental exposures found in the Center for Disease Control handbook, “The ABCs of Safe and Healthy Child Care,” are strongly suggested (see Appendix L). Additional recommendations regarding physical facility are in Appendix M. The EI provider should develop health and safety policies that must minimally contain the following elements:

Health Care Policies: Each provider must have written health care policies that delineates procedures to protect the health and welfare of children and families. All staff must be trained in such procedures. Copies of health care policies and procedures must be made available to HEALTH and families as requested. The health care policy and documentation of staff training must be maintained for HEALTH review. The written health care policy includes, but is not limited to, the following plans and/or procedures:

A plan for the management of infectious diseases. The plan includes:

- criteria regarding signs or symptoms of illness which will determine whether a child or staff member will be included or excluded from home or center-based activities
- policies for when a child or staff member who has been excluded from programming may return
- a procedure for notifying parents when any communicable disease, such as measles or salmonella, has been introduced into the center

A plan for infection control. Procedures are written to include:

- directions for proper hand washing techniques at the center and during home visits
- instructions on the care of toys and equipment used for home visiting and center-based activities
- requirements that staff wear nonporous gloves when they are in contact with bodily fluids
- requirements that contaminated materials are cleaned or disposed of properly
- appropriate requirements for the proper washing and disinfecting of bathrooms and diaper changing areas, including the proper use of toilet training equipment

A procedure for reporting suspected child abuse or neglect to the Department of Children, Youth and Families. The procedure includes assurances that:

- As mandated, all staff will immediately report suspected child abuse or neglect to the Department of Children, Youth and Families or to the program's director or designee, who will immediately report suspected abuse or neglect to the Department of Children, Youth and Families.
- The provider will notify HEALTH immediately after filing the report or learning that the report has been filed, alleging abuse or neglect of a child while in the care of the program or during a program related activity.
- The provider develops and maintains written procedures for addressing any suspected incident of child abuse or neglect by employees, which includes but is not limited to ensuring that an allegedly abusive or neglectful staff member does not work directly with children until the Department of Children, Youth and Families investigation is completed and the allegation is determined to be without foundation or for such a time as HEALTH requires.

Staff Requirements regarding Health and Safety: All direct care staff obtain and maintain certification in CPR and first aid. The CPR curriculum includes CPR for infants and toddlers and the Heimlick Maneuver. The curriculum for first aid includes treatment for seizures and burns, in addition to basic first aid training.

The provider requires before employment or presence at the program of any staff person, regularly scheduled volunteers, and student interns, the following certification from a physician:

- evidence of a physical examination within one year prior to employment
- evidence of immunity for measles, mumps, and rubella
- negative Mantoux TB test in accordance with current HEALTH regulations
- statement of physical limitations in working with children

The examination is valid for two years from the examination date and should be repeated every two years thereafter. Such a certification is not required of any person who states in writing that vaccination or immunization conflicts with his/her sincere religious beliefs or if medically contra-indicated.

A BCI evaluation is completed on, and documented in the personnel file, for each person with the potential for unsupervised contact with children.

Policies and Procedures to Ensure Staff Safety:

- The provider provides for the reasonable safety of staff during home visits. This may include recommendations to staff regarding phoning families before visits, establishing security guard escorts, and/or providing staff in-service on safety issues.

- The provider provides updated information to the staff regarding communicable diseases and preventive health policies.
- The provider provides appropriate security for clients and staff within the provider sites.
- The provider provides appropriate fire safety measures for clients and staff within the provider sites.
- The provider provides an annual in-service on health and safety issues and provides a copy of the program standards at the time of orientation.

Policies and Procedures to Ensure Safety during Center-Based Activities:

- The EI provider provides at least one noncoin operated telephone on the premises for the center use.
- The EI provider posts the following information:
 - the name, appropriate address, and telephone numbers of fire, police, Poison Control Center, ambulance service, nearest emergency health care facility, telephone number and address of the program, including the location of the program in the facility. This information must be immediately visible at each telephone.
 - location of the health care policy and first aid kit
 - emergency and evacuation procedures next to each exit
 - diapering and toileting procedures
 - behavior management policy
- Child group staff have access to information from parents regarding:
 - information regarding allergies and/or other emergency medical information regarding children in group that is provided by the parent upon enrollment
 - the child's daily schedule, developmental history, sleeping and play habits, favorite toys, accustomed mode of reassurance, and comfort
 - procedures for toilet training of the child, if appropriate
 - the child's eating schedule and eating preferences, where appropriate

- the provider has written procedures in place to be followed by staff to avoid the release of children into unsafe situations, if applicable
- The provider has written procedures in place to be followed by staff to communicate or bring special problems or significant developments, particularly as they relate to the child, to the parent's attention as soon as they arise.
- The provider maintains adequate first aid supplies and has a procedure for the use and storage of first aid supplies. The provider maintains adequate first aid supplies, including, but not limited to: adhesive tape, Band-Aids, gauze pads, gauze roller bandage, disposable gloves, instant cold pack, syrup of ipecac, scissors, tweezers, and thermometer.
- The provider has an injury reporting policy which includes, but is not limited to:
 - an injury report that includes the name of child, date, time and location of accident or injury, description of injury and how it occurred, name(s) of witness(es), name(s) of persons(s) who administered first aid or medical care, and first aid or medical care required
 - the assurance that the injury report which requires first aid or emergency care is maintained in the child's file
 - the maintenance of a central log or file of all injuries which occur during program hours and the policy for periodically monitoring the safety record of the provider to identify problem areas
- The provider has written preventive health care procedures:
 - The provider does not admit a child or staff member to the center who has a diagnosed communicable disease (which cannot be contained by universal precautions) during the time when it is communicable and notifies all appropriate parents when any communicable disease, such as measles, mumps and chicken pox has been introduced into the center.
 - The provider monitors the environment daily to immediately remove or repair any hazard that may cause injury.
 - The provider keeps all toxic substances, poisonous plants, medications, sharp objects, matches, and other hazardous objects in a secured place out of reach of children.
 - Provider health records include annual physical and immunization records. All children attending are up to date on immunizations according to recommendation of HEALTH on immunizations, unless medical or religious reasons are documented and are available on admission to group. Children who are not vaccinated may not attend group if it is determined that they may be exposed to an outbreak of a communicable disease. The provider admits a child to group only if provided with a written statement from a

physician which indicates that the child has had a complete physical within one year prior to admission, or obtains one within one month of admission or obtains written verification from the child's parent(s) that they object to such an examination on the ground that it conflicts with their religious beliefs.

- The provider has written procedures for regular toileting and diapering of children and for disposal/cleaning of soiled clothing, diapers and linens.
 - Food provided by the provider is nutritionally and developmentally appropriate for children.
 - The provider follows parental or physician's orders in preparation or feeding of special diets to children and follows the directions of the parents regarding any food allergies of the child or where vitamin supplements are required.
 - The provider stores, prepares, and serves all food and beverages in a manner that ensures that it is free from spoilage and safe for human consumption. The provider provides refrigeration and storage for food at not less than 32° F or more than 45 ° F for food requiring refrigeration. The provider stores all food in clean, covered containers. The provider disposes of milk or food unfinished by a child.
 - The provider provides tables and chairs for use by children while eating which are of a type, size, and design appropriate to the ages and needs of the children. When feeding tables or high chairs are used, they are designed to prevent children from falling or slipping. The provider washes and disinfects the tables or high chair trays used by the children for eating before and after each meal.
 - The provider provides eating and drinking utensils which are appropriate to the age and needs of the children. Eating and drinking utensils are free from defects, cracks and chips. Disposable cups and plates may be used; but if plastic silverware is used, it must be heavy duty and dishwasher proof.
 - The provider provides a source of sanitary drinking water located in/or convenient to rooms occupied by children.
- Providers are required to have at least one site which is accessible in all areas (including bathrooms) to children, staff, and caregivers. If not accessible, an action plan to address the deficiency is filed with HEALTH.
 - All applicable federal and state laws regarding the use of car seats must be adhered to when transporting children to and from EI services.

APPENDIX A

CERTIFIED EI PROVIDER AGENCIES

Families are free to choose their child's EI service coordination agency, regardless of the family's address. All EI service providers provide services on a statewide basis.

CHILDREN'S FRIEND & SERVICE

621 Dexter Street
Central Falls, RI 02863
Phone: 729-0008

JAMES L. MAHER CENTER

120 Hillside Avenue
Newport, RI 02840
Phone: 848-2660

FAMILY RESOURCES COMMUNITY ACTION

245 Main Street
Woonsocket, RI 02895
Phone: 766-0900

MEETING STREET

667 Waterman Avenue
East Providence, RI 02914
Phone: 438-9500

FAMILY SERVICE

55 Hope Street
Providence, RI 02906
Phone: 331-1350

TRUDEAU MEMORIAL CENTER (Kent County Chapter ARC)

250 Commonwealth Avenue
Warwick, RI 02886
Phone: 823-1731

and

134 Thurbers Avenue
Providence, RI 02905

and

153 School Street
Wakefield, RI 02879
Phone: 783-6853

HASBRO CHILDREN'S HOSPITAL

593 Eddy Street
Providence, RI 02903
Phone: 444-3201

APPENDIX B

DEFINITIONS OF TERMS

Certified EI Provider means an EI Provider that is in compliance with the Standards set forth by HEALTH.

Children means infants and toddlers from birth to 36 months who need EI Services.

Days means calendar days.

Destruction means physical destruction or removal of personal identification from information so that information is no longer personally identifiable.

Due Process means the regulations established by HEALTH for EI Providers certified by HEALTH with respect to notice of rights, informed consent, records, and confidentiality appeals and complaints.

EI Program means the total effort in a state that is directed at meeting the needs of eligible children and families.

Early Intervention Services (EIS) means services that:

- are designed to meet the developmental needs of each child and family related to enhancing the child's development
- are selected in collaboration with parents;
- are provided by a HEALTH certified EI program;
- are provided by qualified personnel, when required
- are provided in conformity with an Individualized Family Service Plan (IFSP)
- are provided at no cost

General Role of Service Providers means service providers are responsible for:

- consultation with parents, other service providers, and representatives of other appropriate agencies to ensure the effective provision of service
- training parents and others regarding the provision of services
- participating in the multidisciplinary team's assessment of a child and the child's family and in the development of integrated goals and outcomes of the IFSP

Individualized Family Service Plan (IFSP) means a written plan for providing EI services to an eligible child and the child's family in accordance with federal regulations and EI Operational Standards.

Infants and Toddlers with Disabilities means individuals from birth to 36 months who need EI Services because they:

- are experiencing developmental delays as measured by appropriate diagnostic instruments and procedures in one or more of the following areas: cognitive development, physical development (including vision and hearing), communication development, social or emotional development, adaptive development; or
- have a diagnosed physical or mental condition that has a high probability of resulting in developmental delay.

This may include children who are at risk of substantial developmental delays if EI Services are not provided at the discretion of the state (see Eligibility).

Multidisciplinary means the involvement of two or more disciplines or professions in the provision of integrated and coordinated services, including evaluation and assessment activities and development of the IFSP.

Native language means the language or mode of communication normally used by the parent of child seeking or using services. If the parent is vision or hearing impaired, the mode of communication is that normally used by the parent, such as sign language, Braille, oral communication, or other appropriate mode of communication.

Natural Environments means to the maximum extent appropriate to the needs of the child, EI Services must be provided in settings, including the home and community, in which children without disabilities participate. This also means settings that are natural or normal for the child's age peers who have no disability. Services are delivered elsewhere only when EI cannot be achieved satisfactorily for the infant or toddler in a natural environment.

Parent means (1) a natural or adoptive parent of a child, (2) a guardian, (3) a person acting in the place of a parent (such as a grandparent or stepparent with whom the child lives, or a person who is legally responsible for the child's welfare), (4) a surrogate parent who has been assigned in accordance with state policy and procedure, or (5) a foster parent who has been appointed the surrogate parent, if the natural parents' authority to make decisions on the child's behalf has been removed under state law, and the foster parent has an ongoing, long-term parental relationship with the child and is willing to make the decisions required of parents under the Act, and has no interest that would conflict with the interests of the child and has been appointed the surrogate.

Parental Consent means that the parent(s) have been fully informed of all information relevant to the activity for which consent is sought, in the parent's native language or other mode of communication, the parent understands and agrees in writing to the carrying out of the activity

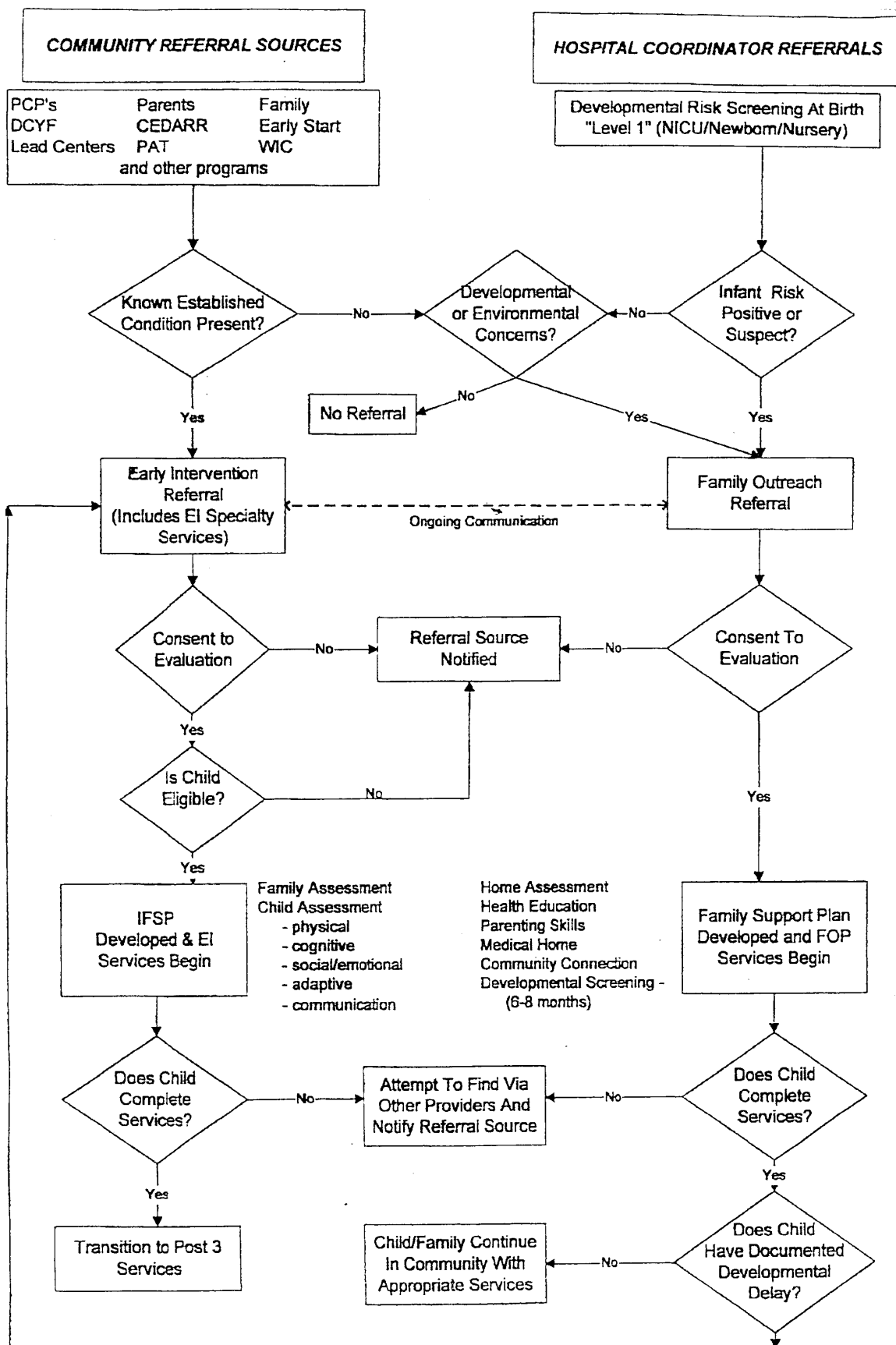
for which consent is sought, the consent describes that activity and lists the records (if any) that will be released and to whom, and the parent understands that the granting of consent is voluntary and may be revoked at any time.

Personally identifiable information means information that includes the name of the child, parent, or other family member; address of child; personal identification, e.g., child or parents social security number, or list of personal characteristics or other information that makes a child's identity reasonably certain.

Qualified Personnel means person(s) who have met State approved or recognized certification, licensing, registration, or other comparable requirements that apply to the area in which they are providing EI Services (see Section IV for additional information).

Service Coordination means the activities carried out by a service coordinator to assist and enable an eligible child and the child's family to receive the rights, procedural safeguards, and services that are authorized to be provided under the State's EI system.

APPENDIX C – R.I. CHILD FIND SYSTEM (Birth to Age Three)



APPENDIX D

LIST OF COMMONLY USED TOOLS FOR EVALUATION AND ASSESSMENT

All providers are encouraged to use curriculum compatible measures that facilitate the integration of information from a variety of developmental areas and disciplines.

- AIMS
- AEPS
- Batelle Developmental Inventory (BDI)
- Bayley Scales of Infant Development – Revised
- Birth to Three Assessment and Intervention System: Parent Teacher Interaction Program
- Brigance Inventory of Early Development – Revised
- Carolina Curriculum for Infants and Toddlers with Special Needs, Second Edition
- Child Behavior Checklist (Achenbach)
- Communication and Symbolic Behavior Scales
- Early Learning Accomplishment Profile (ELAP)
- Gesell-Armatruda Neurological and Developmental Examination
- Hawaii Early Learning Profile (HELP)
- Infant Development Assessment (IDA)
- Infant Toddler Family Instrument
- McCarthy Scales of Children’s Abilities
- Mullen Scales of Early Learning, Michigan
- NCAST
- Peabody Developmental Motor Scales
- Peabody Picture Vocabulary Test – Revised (PRVT-R)
- Receptive Expressive Emergent Language Scale Test (REEL-2)
- Rosetti Infant Toddler Language Scale
- Stanford Binet Intelligence Scales - 4th Edition
- Transdisciplinary Play-Based Assessment (Linder, 1993)
- Vineland Adaptive Behavior Scales
- Vulpe Assessment Battery

In addition to one or more of the above, the following should be utilized:

- Clinical Observations
- Parent Report/Parent Observations

The measures listed below are being reviewed for use in EI:

- Albertor Motor Assessment
- Motor Maturity Scale
- Neonatal Behavioral Assessment Scale (Brazelton)
- NNNS
- Postural and Fine Motor Assessment of Infants
- Sequenced Inventory of Communication Development

APPENDIX E

REPRESENTATIVE LIST OF ESTABLISHED CONDITIONS (SEC)

Genetic Disorders:

A. Chromosomal Abnormality Syndromes

B. Neurocutaneous Syndromes

Sturge-Weber Syndrome

Tuberous Sclerosis

C. Inborn Errors of Metabolism

i. Amino Acidopathies

Organic Acidemias

Glutaric Aciduria type II

ii. Very long chain fatty acid storage diseases, all (includes Peroxisomal Diseases, lipid metabolism abnormality)

iii. Mucopolysaccharidoses (carbohydrate metabolism abnormality)

iv. Purine/pyrimidine abnormalities (i.e., Lesch Nyhan Syndrome)

D. Other Syndromes:

Achondroplasia (dwarfism)

Apert Syndrome

Angelman Syndrome

Bardet-Beidl Syndrome

CHARGE Syndrome

Cornelia de Lange Syndrome

Fragile X

Jeune Syndrome

Lissencephaly Syndrome

Menkes Syndrome

Muscular Dystrophy

Noonan Syndrome

Opitz Syndrome

Osteogenesis Imperfecta – types 2 & 3

Pallister- Killian Mosaic Syndrome

Prader-Willi Syndrome

Rubinstein-Taybi Syndrome

Russell Silver Syndrome

Weaver Syndrome
Williams Syndrome

Sensory Impairments:

Congenital or acquired
Auditory Neuropathy
Blindness (“legal” blindness or 20/200 uncorrected 20/70 with best correction)
Enophthalmos/microphthalmos of the eye
Hearing Impairment (40dB loss or greater)
Sensory Integration Impairment

Motor Impairments:

Arthrogryposis/ Multiplex Congentia
Severe Scoliosis

Neurologic Disorders:

Agenesis of the Corpus Callosum
Anencephalus
Arnold-Chiari Malformation
Brain Malformation
Central Congenital Hypoventilaion Malformation
Cerebral Dysgenesis
Cerebral Palsy (all types)
Degenerative Progressive Neurological Condition
Encephalopathy
Holoprosencephaly
Hydrocephaly, congenital or acquired
Kernicterus
Neural Tube Defects
Microcephalus
Peri-ventricular Leukomalacia (PVL)
Porencephalic Cyst
Seizures (poorly or not controlled)
Spinal Muscular Atrophy/ Werdnig Hoffman Disorder
Stroke
Syringomyelia

Sociocommunicative Disorders:

Asperger Syndrome
Autism
Childhood Disintegrative Disorder
PDD – NOS

Medically Related Disorders:

Cleft Palate
Craniosynostosis with Syndrome

Pediatric AIDS/ HIV (+)
Hypoplastic left heart syndrome
Lung Hypoplasia
Pulmonary Atresia
Respiratory Insufficiency/Oxygen Dependency
Severe Burns
Very Low Birth Weight (<1,500 grams {3 lbs.} at birth)

Acquired Trauma Related Disorders:

Traumatic Brain Injury/ TBI
Spinal cord Injury

Prenatal Influences:

- A. Prenatal exposures
 - Fetal Alcohol Syndrome
 - Fetal Phenytoin (Dilantin) Syndrome
- B. Prenatal infections
 - Congenital Toxoplasmosis
 - Congenital Rubella
 - Congenital CMV (cytomegalovirus)
 - Congenital Herpes
 - Congenital Syphilis
- C. Perinatal events
 - Severe birth asphyxia
 - Chronic lung disease due to prematurity

APPENDIX F

IFSP DOCUMENTATION **(COMPLETING THE IFSP FORM)**

Overview:

- Use pen. The IFSP form may be obtained from HEALTH and filled in by typing in responses; however, since it is expected that the form be completed with the family (unless otherwise noted in this document), a written draft would be completed with the family, typed, and then finalized with the family. This could also be done if a laptop was available during the IFSP meeting.
- Fill in all spaces (unless otherwise noted in this document). If a line or area is not applicable, fill in “not applicable” or “NA.”
- While the form itself may not be altered in any way, the IFSP team may add pages, if needed.
- Do *not* use white-out or black out errors so they can no longer be read. To make a correction, draw a single line through the error; initial and date this change.

General Information:

This page is intended to provide both identifying information and to act as a quick reference for IFSP team members.

With the exception of the IFSP effective dates, this section can be filled out prior to the IFSP meeting. The family must be offered the opportunity to review the information written.

- The term special accommodations in this context refers primarily to accommodations needed to ensure that the family and invited team members can participate fully in IFSP development. The two most frequently needed accommodations are interpretation and transportation. Because the accommodations refer to the IFSP meeting, the need for accommodations must be discussed with the family prior to the meeting. Accommodations needed for participation in the attainment of IFSP goals must be documented on the goal pages of the IFSP.
- Generally, IFSPs are written for one year; however, they may be written for a period of less than a year as agreed by the IFSP team. For example, the IFSPs of children who enter EI under professional judgment would typically be written for six months, as a re-evaluation and assessment is expected at six months.

- Remember to document the reasons why an IFSP is overdue/out of compliance at the bottom of the General Information section.

Family Page:

This page takes the place of the old “family assessment.” It reflects the current thinking that we, as professionals, are *not* “assessing” or judging families but rather are listening to families and supporting them as they organize their thoughts and feelings around their own strengths and needs as related to supporting their child’s development.

- This page is optional; it is the choice of the family.
- This page may be filled out either by EI staff using an interview format, or it may be given to families to fill out prior to the IFSP meeting, if the family would like.

Child Development Evaluation and Assessment Summary:

These pages are designed to stand alone as the evaluation and assessment summary, which is why there is some repetition of the information in the General Information section. Completing these pages meets HEALTH requirements for the evaluation and assessment summary. If programs require an additional write-up, it may be attached at the end of this section, but it may *not* substitute for the completion of this section of the IFSP.

It is expected that these pages reflect a strength based orientation, use nontechnical language, and strive to integrate both discipline specific input and family input. Professionals should promote the view that all infants and toddlers are adaptive and competent. This is critically important in sharing with parents a positive, hopeful image of their child. This positive image is a key determinant of positive outcomes for children and families. Using a strength based approach means that information is gathered with the goal of determining what skills have been obtained and can be considered the basis for new developmental gains.

The use of nontechnical language reflects the importance of making evaluation and assessment accessible to caregivers so that they can fully participate in IFSP development and service delivery. Technical terms should only be used in conjunction with lay descriptions (e.g., put the technical term in parentheses after the lay description)

Developmental domains are clearly interrelated, particularly in the very young children EI serves. It is important that professionals move beyond discipline specific knowledge to focus holistically on the child in the context of family and community for the purpose of effective intervention planning. The burden of integrating such information should not be placed on caregivers. The following information is adapted from “Best Guidelines for Reports” and a variety of personal communications:

- Because at least one of the assessment tools used must be norm-referenced, developmentally based, curriculum based, or otherwise recognized as meeting objective, Professional Standards, Parent Report, and Clinical Observation must not be listed as the only methods used.
- Parent(s) must always be listed as participating in the child's evaluation.
- Level 1 refers to the universal screening done at birthing hospitals; Level 2 refers to screening done by the Family Outreach Program. If they are not available, indicate so.
- The purpose of the Developmental Overview Summary is to provide an integrated perspective on the child's development. The integration of information may be facilitated by addressing functional concerns or specific issues raised by caregivers.
- ____=____ is intended to provide a place to record standard or developmental scores (e.g., t=59). At the parent's request, scores may be omitted from the IFSP document by drawing a line through ____=____. However, the appropriate information must be recorded into EIMIS.
- Blank boxes may be used at the discretion of the provider or IFSP team. Examples of information that might be added include behavioral observations or articulation.
- If the results of an evaluation indicate an area of delay, that information must be shared with families. However, if that delay is not of concern to the family, indicate so in the Concerns box. In such cases, it would not be anticipated that EI services would be needed.
- In the section that requires Eligibility and ICD-9 Codes be documented, write out the information (e.g., Developmental Delay rather than DD).
- This is *not* the section to (nor should additional program evaluations) make recommendations regarding the frequency and duration of specific services. Professionals must spend at least as much time influencing the child's daily environment as providing direct therapy. Thus specific recommendations must come after the child's daily environment is understood and goals have been developed.

Natural Environments:

The purpose of this section is to begin the process of identifying natural learning opportunities available in the family's daily life. Information gathered in this section must cover not only *where*, but also *who* (is involved), *what* happens during routines, and possibly *how* the routines are going. This information is critical for goal and strategy development.

For example, if a child eats two of three meals at child care, then the child care provider should play a role in any goal related to feeding. Additionally, if a routine is difficult for a family (i.e., bath time), then the team should consider whether a goal related to bath time is needed. Conversely, if there is a well established routine, such as reading a story before bed, then that routine may afford the opportunity to work on a goal on language development.

This section also ensures that we plan how our work with children and families will be generalized into other aspect of their lives.

- In the section that asks for justification of services in a non-natural environment, attention must be paid to developing a plan to be able to provide those services in a natural environment.

Transition Planning:

- This section must be filled out for all children regardless of age. The dialogue about this section will vary with child's age.
- It is anticipated that all children will be referred to the local school department and parents will be encouraged to have the 30-month meeting. This is because *both* EI and the school department have an obligation to support the parent(s) in learning about family support and early childhood options instead of preschool special education, in the event that children are not eligible for services through special education. This decision is made on an individual basis, and the parent(s) may decline the referral and the 30-month meeting.
- A written transition plan *must* be attached to the IFSP after the 30-month meeting has been completed.

Outcomes:

- More pages may be added as needed and numbered as 8A, 8B, etc. More goal pages can also be added to the IFSP at any time that a family and a service provider together decide to do so. Since goal pages may be added after the IFSP is signed, the parent must initial all goal pages.
- In general, the family primarily determines the major outcomes, that is, what they would like to happen. It is appropriate and encouraged to use the family's own words in quotation marks when writing goals. In addition, goals must be functional. A sample structure to remember when writing goal is: "the family would like..... in order to....."
- EI staff uses their clinical skills to develop the strategies that will be used to attain goals in conjunction with families. These strategies must be developed with the information obtained in the Natural Environments section of the IFSP firmly in mind.
- Since it is the philosophy of EI in Rhode Island that parents and other caregivers will be involved in the implementation of the strategies in the IFSP, then the IFSP must delineate the strategies in sufficient detail for this to occur *or* delineate how the needed information will be shared with parents and caregivers. It is *not* acceptable to write a service as a strategy.

- Criteria/ Evaluation must be written in sufficient detail to allow consensus regarding outcome upon IFSP review. For example, if goals refer to increasing or decreasing behavior, then baseline data must be documented.
- Date of review can be six months or less at the discretion of the IFSP team. When a review is held, the IFSP review page must be completed. In general, the date of completion should coincide with date of review. On the date of review, the status of the goals must be rated using the data collected. Although any team member can write goals with a family at any time, the service coordinator must be present at all IFSPs and IFSP reviews. Additionally, a service or service frequency can only be changed through an annual IFSP or IFSP review.

Early Intervention Services – Summary:

- More pages may be added as needed and numbered as 9A, 9B, etc.
- The information above the gray box is for EIMIS purposes and is optional but should be used if pages are separated.
- Frequency, Intensity, and Duration must be consistent statewide. The chart on the next page must be used for entering this information into EIMIS.
- The IFSP must be reviewed at least every six months; therefore, duration is no more than six months.
- The IFSP in the EIMIS can be updated to reflect a six-month review (or sooner). Please note that if services change (including frequency change), the service must be added to the IFSP, and the old service end date should be updated. (A new IFSP needs to be added into the system every year).
- Durations of seven to twelve months only should be used on or after the six-month IFSP review. After a six-month review, if a service is to continue for another six months, the only update in the data would be for duration changed to twelve months.
- If “no” is indicated in the Natural Environments column, justification on page 7 must be completed.
- The other services section is intended for services which are not EI services, but which should be considered in service coordination (i.e., non-EI medical services). This section should also be used for those services which are EI services but which are provided by another agency (i.e., nutrition through Early Head Start). With family consent, such services must be addressed through service coordination and should be documented in EIMIS.

Code Duration	Description Based on 6-month Service limit	Code Frequency	Description based in weekly services	Code Intensity	Description
1	1 month	0.16	Once in 6 months	30	30 minutes
1.5	1 to 2 months	0.33	Twice in 6 months	45	45 minutes
2	2 months	0.5	Three time in 6 months	60	60 minutes
2.5	2 to 3 months	0.66	Four times in 6 months	90	90 minutes
3	3 months	0.83	Five times in 6 months	120	120 minutes
3.5	3 to 4 months	1	Once a month	150	150 minutes
4	4 months	2	Twice a month	180	180 minutes
4.5	4 to 5 months	3	Three time a month	210	210 minutes
5	5 months	3.5	Once every three weeks	240	240 minutes
5.5	5 to 6 months	4	1 times a week	270	270 minutes
6	6 months	6	1 to 2 times a week	300	300 minutes
7	7 months	8	2 times a week	330	330 minutes
7.5	7 to 8 months	10	2 to 3 a week	360	360 minutes
8	8 months	12	3 times a week	390	390 minutes
8.5	8 to 9 months	14	3 to 4 times a week	420	420 minutes
9	9 months	16	4 times a week	450	450 minutes
9.5	9 to 10 months	18	4 to 5 times a week	480	480 minutes
10	10 months	20	5 times a week		
10.5	10 to 11 months				
11	11 months				
11.5	11 to 12 months				
12	12 months				

Payment Sources:

The purpose of the financial intake/information meeting is to answer any questions families have regarding EI funding and to educate families about the questions they may wish to consider before authorizing EI to access private insurance as a potential funding source. This is so that families can make an informed decision regarding use of private insurance on this page.

Families may deny access to private insurance. If families choose not to use private insurance, providers may not require an explanation of this decision from families or provide different services to such families. Additionally, while it is permissible to gather information regarding type of insurance coverage, it is *not* permissible to request specific private insurance policy information (i.e., policy #) until a family has indicated that their private insurance may be used.

HEALTH will only consider the information obtained on the IFSP regarding accessing private insurance. If a family's decision changes, it must be documented on an IFSP Review. As

Medicaid programs do not have a “cap,” use of Medicaid is not considered to be a cost to the family and thus can be utilized as a funding source for all children enrolled in a Medicaid program (including RIte Care programs).

Acknowledgment of the IFSP:

- The parent and the service coordinator must sign the IFSP. Other team members can be listed or can sign. Community partners, such as child care providers, are encouraged to participate in IFSP development with parent consent. When community partners have participated in IFSP development, they must be listed as team members.
- If the IFSP meeting was interpreted on behalf of the family, the interpreter should sign as a team member and indicate his/her role as an interpreter.
- Remember to have parents check two lines (approve or not approve and procedural safeguards), in addition to signing this page.

IFSP Review:

- This page must be completed at any time the IFSP is reviewed.
- Additional goal and service pages can be attached to the IFSP review as needed.
- The service coordinator must be present at all IFSP reviews. Additionally, a service or service frequency can only be changed through an annual IFSP or IFSP review.

APPENDIX G

TRANSITION TO PARTNERSHIPS IN RHODE ISLAND

Timeline	Activities	Strategies	Persons Involved
At entrance of EI	Provide overview of transition process	General information sharing re transition activities/process, future service agencies	EI Service Coordinator Parents
On a yearly basis	LEA is informed about numbers of children most likely needing special services and turning three the following year	EI prepares and reports the number of children to LEA	EI Director LEA administrator
24-30 months	Provide education/information for parents re overview of transition process and future services	Parent-to-parent contacts, parent education/support groups; focus on parents rights and responsibilities, procedural safeguards, state regulations, program continuum	EI Service Coordinator Parents
28 months	EI referral to LEA	EI staff and parent complete forms; parent signs permission for release	EI Service Coordinator Parents
28 months	Complete survey of child's strengths/needs	Complete form, indicating child's skill levels, child and family's current services in the EI program, and involvement with other professionals and agencies; send to LEA with referral	EI Director EI Service Coordinator Parents
29 months	Planning for Transition Team Meeting	Discussion of transition process, members of the transition team and their roles, and goals for meeting	
30 months	Transition Team Meeting 1	<p>Transition Team shares description of child's functioning skill level, child's and family priorities for services in LEA, and survey of LEA program continuum</p> <p>LEA shares R.I. Regulations and procedural safeguards with family</p> <p>Transition Team makes decisions regarding activities to occur to ensure a smooth transition, persons responsible for activities, timelines to ensure completion of activities, evaluation processes, information exchange system, decision-making processes, records to be transferred, follow-up procedures, contact persons on Transition Team, and appointment for LEA observation of child in home or center</p>	<p>Parents EI Staff EI Service Coordinator Administrator</p> <p>LEA Administrator/primary contact person Service Provider Others</p>

		Transition Team develops and documents an Individual Transition Plan specifying the activities to take place, the timelines, and persons responsible for carrying out these activities	
30-33 months	Observation of child by LEA	LEA observes child in natural setting	Parents EI Service Coordinator LEA staff
30-33 months	Final team evaluation	EI team members and LEA team members complete evaluations with agreed upon assessment tools*	Parents EI team member LEA team members
30-35 months (may occur before or after TTM 2 at team's discretion)	Parents and EI staff visit placement options	Appointments are made to visit placement options with LEA contact person	Parents EI staff LEA staff
35 months	Transition Team Meeting 2	Transition Team meets to give feedback re evaluation results, exchange evaluations from EI and LEA, give copies to parents, and arrive at a consensus decision on program options to be visited	Transition Team
35 months	IEP meeting	Parent, LEA, and EI develop goals and objectives together, documenting placement, support services, etc.	Parents LEA staff EI Service Coordinator
35 months	Orientation to new program	Parents and EI Service Coordinator meet with Receiving Teacher to discuss child's program, specific needs in classroom, adaptation, physical equipment, transportation, plan for child's first day, etc.; establish communication links between teacher and parent	Parents EI Service Coordinator LEA Receiving Teacher and any other special service personnel in LEA
36 months	Placement	Child begins services	LEA Receiving Teacher Parents Child

*It is the responsibility of the LEA to complete all evaluations required to make eligibility decisions. However, it may be clinical best practice for EI staff to complete some of the needed evaluations. This should be discussed at the TTM1, and a special request made to HEALTH if more than one evaluation will be completed in a given year.

SURROGATE PARENT DETAILED PROCEDURE

When a referral indicates that a child is in DCYF custody:

EI Intake worker calls DCYF caseworker:

- informs caseworker of the referral
- provides brief explanation of EI
- explains that parents will retain their rights to make decisions for child within EI *unless* they choose not to *or* do not step forward
- learns from caseworker if there are any court-imposed limitations to parents' involvement (e.g., a restraining order); this does *not* mean that the parents are unable to retain their rights in EI, but that special arrangements for them to do so may need to be made
 - discusses any other barriers/limitations that may impact on next steps (i.e., language or literacy concerns)
 - asks caseworker what DCYF legal status is with this child and documents the response in the child's record with the name of the person providing the information and the date and method of communication (i.e., telephone); asks the DCYF caseworker to provide written confirmation of case status for the child's record
 - ◆ parental rights terminated (TPR); surrogate parent to be appointed
 - ◆ parent(s) whereabouts unknown; surrogate parent to be appointed
 - ◆ voluntary placement; parent(s) wish to retain rights to make educational decisions

- ◆ voluntary placement; parent(s) waive rights to make educational decisions; surrogate parent to be appointed.
- ◆ child is in temporary or permanent custody on an abuse/neglect or dependency petition and resides in home with birth parents; parent(s) retain rights to make educational decisions
- ◆ child is in temporary or permanent custody on an abuse/neglect or dependency petition and resides out of home; parent(s) sent letter indicating the parent must contact HEALTH within ten days to indicate intention to retain rights to make educational decisions; otherwise, a surrogate parent will be appointed

Determination of next steps:

- No special steps are required if (a) voluntary placement and parent(s) wishes to retain rights to make educational decisions, or (b) child is in temporary or permanent custody on abuse/neglect or dependency petition and resides in home with birth parents. Parent(s) retains all rights; and the intake, evaluation/assessment, and IFSP processes continue as for all other children.
- If parental rights are terminated or parent(s) whereabouts are unknown, EI will initiate assignment of surrogate parent and proceed with referral as follows:
 - Discuss assignment of surrogate with DCYF worker. Ask if there is an interested relative who could act as surrogate for this child.
 - ◆ If a person is identified by DCYF worker, ask if s/he can be contacted by DCYF worker and inquiry made regarding their interest in fulfilling this role (the person should be contacted within ten days, or alternative may need to be selected). Training will be provided by EI through RIPIN, and assignment will be made by HEALTH.
 - ◆ If there is no available relative, then the foster parent will be contacted by the EI provider, given a brief description of the surrogate parent program, asked about interest, and, if willing, the process for training and assignment will proceed.
 - ◆ If the foster parent is unable to act as a surrogate parent, a trained volunteer will be appointed by HEALTH.
 - Send packet of information and release forms to DCYF worker for signature by regional manager. Packet should include:
 - ◆ information about EI
 - ◆ medical releases for pediatrician and birth records

- ◆ other medical releases as needed
- ◆ release for exchange of information with DCYF
- ◆ a check-off form to confirm child's legal status
- Call Surrogate Parent Coordinator at HEALTH to ask for an appointment of the identified potential surrogate parent.
- Once the surrogate parent is appointed, the intake process can proceed while awaiting return of the medical releases. Proceed with evaluation/assessment when consents have been signed by the appointed surrogate parent.
- If (a) voluntary placement where parent waives rights to make educational decisions and surrogate parent to be appointed, or (b) child is in temporary or permanent custody on an abuse/neglect or dependency petition and resides out of home; parent(s) sent letter indicating the parent must contact HEALTH within ten days to indicate intention to retain rights to make educational decisions; otherwise, a surrogate parent will be appointed:
 - Explain procedure to determine if parent may retain signing rights for child within EI:
 - ◆ Get the last known address from DCYF caseworker, and ask DCYF caseworker to inform parent that a letter will be coming from HEALTH and that the parent must respond to this letter if they wish to retain their rights in EI.
 - ◆ Mail packet to DCYF worker and ask for his/her assistance in getting releases signed by biological parent. Attempt to get these signatures, even if the biological parent does not intend to retain signing rights, in order to expedite gathering of information, and to perform intake and evaluation/assessment. When the signed releases are received, the provider can proceed with intake and evaluation/assessment. IFSP development and signature should be completed after the decision of who represents the child is finalized. The package must include:
 1. medical releases for pediatrician and birth records
 2. "consent to enroll" form (if used by agency)
 3. "consent to evaluate" form
 4. other medical releases, as needed
 5. release for exchange of information with DCYF
 6. information about EI
 7. a check-off form to confirm child's legal status
 - ◆ Call the Surrogate Parent Coordinator at HEALTH to inform him/her that a letter needs to go out to biological parent. Ask the Surrogate Parent Coordinator to standby to receive a fax with the child's name, date of birth, biological parent's name, and last known address of biological parent. The Surrogate Parent Coordinator will send letter and a copy of procedural safeguards to the biological parent, who has ten days to respond.

1. If the biological parent does not respond within ten days, then assignment and training of a surrogate parent will proceed. However, the EI service coordinator should work with the DCYF caseworker to encourage the birth parent's involvement at an appropriate level.
2. If the biological parent does respond and wishes to retain his/her rights in EI, the Surrogate Parent Coordinator will inform him/her that he/she will be hearing from the EI intake worker or service coordinator.
 - a. The provider is notified. The intake worker or service coordinator contacts the parent and describes EI program and asks the parent how he/she would like to be involved. These choices need to be framed in terms of any limitations regarding parent involvement, per DCYF. Choices may include receiving a written or verbal update from the EI provider, receiving copies of service notes, participating in the IFSP, participating in other meetings, and full participation. A plan is made with biological parent regarding the degree of participation the parent wishes to have in evaluation/assessment, IFSP development, and provision of services. It is preferable in most circumstances for the parent to participate in the IFSP meeting. If the parent does not attend, the IFSP must be signed by parent *before services can begin*.
 - b. The service coordinator is responsible for documenting all attempts to contact the biological parent or any missed appointments that interfere with the provision of EI services. If s/he is unable to contact the biological parent, the service coordinator must inform the Surrogate Parent Coordinator, and a letter will be sent again to determine the parent's continued involvement or need for a surrogate parent to be assigned.
 - c. When the parent is not present for services, a foster parent or other caregiver can sign service notes, using his/her initials or "foster parent."

APPENDIX I

DCYF STATUS

Child's Name: _____ DOB: _____

Please provide confirmation of case status for the child's EI record (check one):

_____ Parental Rights terminated (TPR). Surrogate parent to be appointed.

_____ Parent(s) whereabouts unknown. Surrogate parent to be appointed.

_____ Voluntary placement. Parent(s) wishes to retain rights to make educational decisions.

_____ Voluntary placement. Parent(s) waives rights to make educational decisions. Surrogate parent to be appointed.

_____ Child is in temporary or permanent custody on an abuse/neglect or dependency petition and resides in home with birth parents. Parent(s) retain rights to make educational decisions.

_____ Child is in temporary or permanent custody on an abuse/neglect or dependency petition and resides out of home. Letter sent to parent(s), indicating the parent must contact HEALTH within ten days to indicate intention to retain rights to make educational decisions. Otherwise, a surrogate parent will be appointed.

DCYF Caseworker Signature

Date

PLEASE RETURN TO: Service Coordinator: _____
Address: _____

PLEASE NOTIFY THE EI PROGRAM IMMEDIATELY IF THERE ARE ANY CHANGES IN THE CHILD'S STATUS. THANK YOU.

APPENDIX J

SAMPLE OF RECORD COLLECTION INFORMATION NOTICE REGARDING THE COLLECTION AND MAINTENANCE OF EI RECORDS

(Provider name) maintains a written record of each child in our EI Program. Your child's record contains information about your child's participation in EI. This information is used to monitor the quality of our services. Examples of the information in your child's record include your child's evaluations and IFSP, service notes, information that you've given us permission to obtain from other people involved in your child's care, and the releases of information you've signed allowing us to share information with other people involved in your child's care. Your child's record is considered confidential. This means that:

- We will *not* share your child's record with anyone outside our agency and the Department of Health (which oversees EI programs) without your permission, unless we are required to do so by law.
- Any reports produced for use outside of our agency will in no instance contain personal identification of you or your child without your written permission.
- Your child's record will be stored in a locked file or locked room.
- You may request to see your child's file and, if needed, request changes to that file at any time.
- Your child's record may be destroyed, not less than seven years after discharge from the EI Program.

If you have any questions regarding your child's record, please contact _____.

In addition to the information stored in your child's record, the Department of Health maintains a computerized record keeping system to monitor our program and to plan for the future needs of the EI system. Please be assured that this computerized information is also strictly protected. Access to the computerized record is protected by use of log-in passwords for authorized users.

- Any reports produced for use outside of EI will in no instance contain personal identification of you or your child without your written permission.
- You may inspect and review the system's records for information regarding your child at any time.
- Limited information, such as your dates of participation in EI, will be available in KIDSNET, unless you do not want to be a part of KIDSNET. KIDSNET is a computer network that

keeps your pediatrician and other health service providers in touch with each other. If you have any questions about KIDSNET or do *not* want to be a part of KIDSNET, please call the KIDSNET Help Desk at 222-4220.

If you would like any other information regarding the Department of Health's information system, please ask your service coordinator or contact the Early Intervention Quality Assurance Coordinator at 222-5956.

APPENDIX K

SAMPLE COMMUNITY PARTICIPATION LOG

***PROVIDER NAME* COMMUNITY PARTICIPATION**

Community Agency, Contact, etc.: _____

Address: _____

Location of Participation: _____

Date of Participation: _____

Time of Participation: _____

Description of Participation (e.g., event, committee, etc.): _____

APPENDIX L

“THE ABC’S OF SAFE AND HEALTHY CHILD CARE” **(ADAPTATION FROM CDC)**

CLEANING AND DISINFECTION

Routine cleaning with soap and water is the most useful method for removing germs from surfaces. Good mechanical cleaning (scrubbing with soap and water) physically reduces the numbers of germs from the surface, just as hand washing reduces the numbers of germs from the hands. Removing germs is especially important for soiled surfaces which cannot be treated with chemical disinfectants, such as some upholstery fabrics.

However, some items and surfaces should receive an additional step, disinfecting, to kill germs after cleaning with soap and rinsing with clear water. Items that can be washed in a dishwasher or hot cycle of a washing machine do not have to be disinfected because these machines use water that is hot enough for a long enough period of time to kill most germs.

The disinfecting process uses chemicals that are stronger than soap and water. Disinfecting usually requires soaking or drenching the item for several minutes to give the chemical time to kill the remaining germs. Commercial products that meet the Environmental Protection Agency’s (EPA’s) standards for “hospital grade” germs may be used for this purpose.

One of the most commonly used chemicals for disinfecting in childcare settings is a homemade solution of household bleach and water. Bleach is cheap and easy to get. The solution of bleach and water is easy to mix, is nontoxic, is safe if handled properly, and kills most infectious agents. (Be aware that some infectious agents are not killed by bleach. For example, ammonia or hydrogen peroxide only kills cryptosporidia.)

Recipe for Bleach Disinfecting Solution (for use in bathrooms, diapering areas, etc.):

¼ cup bleach
1 gallon of cool water
OR
1 tablespoon bleach
1 quart cool water

Add the household bleach (5.25% sodium hypochlorite) to the water.

Recipe for Weaker Bleach Disinfecting Solution (for use on toys, eating utensils, etc.):

1 tablespoon bleach
1 gallon cool water

Add the bleach to the water.

A solution of bleach and water loses its strength very quickly and easily. Organic material evaporation, heat, and sunlight weaken bleach water. Therefore, bleach solution should be mixed fresh each day to make sure it is effective. Any leftover solution should be discarded at the end of the day. *Never* mix bleach with anything but fresh water! Other chemicals may react with bleach and create and release toxic chlorine gas.

Keep bleach solutions you mix each day in a cool place, out of direct sunlight and out of the reach of children. Although a solution of bleach and water mixed as shown in the above recipes should not be harmful if accidentally swallowed, you should keep all chemicals away from children.

If you try a commercial (brand name) disinfectant, read the label and always follow the manufacturer's instructions exactly.

WASHING AND DISINFECTING TOYS

Infants and toddlers should not share toys. Toys that children (particularly infants and toddlers) put in their mouths should be washed and disinfected between individual uses. Toys for infants and toddlers should be chosen with this in mind. If you can't wash a toy, it probably is not appropriate for an infant or toddler.

When an infant or toddler finishes playing with a toy, you should retrieve it from the play area and put it in a bin reserved for dirty toys. This bin should be out of reach of the children. Toys can be washed at a later, more convenient time, and then transferred to a bin for clean toys and can then be safely reused by other children.

To wash and disinfect a hard plastic toy:

- Scrub the toy in warm, soapy water. Use a brush to reach into the crevices.
- Rinse the toy in clean water.
- Immerse the toy in a mild bleach solution (see above) and allow it to soak in the solution for 10–20 minutes.
- Remove the toy from the bleach solution and rinse well in cool water.
- Air dry.

Hard plastic toys that are washed in a dishwasher or cloth toys that are washed in the hot water cycle of a washing machine do not need to be additionally disinfected.

Children in diapers should only have washable toys. Each group of children should have their own toys. Toys should not be shared with other groups.

Stuffed toys used by only a single child should be cleaned in a washing machine every week, or more frequently, if heavily soiled.

Toys and equipment used by older children and not put into their mouths should be cleaned at least weekly and when obviously soiled. A soap and water wash, followed by clear water rinsing and air drying, should be adequate. No disinfecting is required. (These types of toys and equipment include blocks, dolls, tricycles, trucks, and other similar toys).

Do not use wading pools, especially for children in diapers.

Water play tables can spread germs. To prevent this:

- Disinfect the table with chlorine bleach solution before filling it with water.
- Disinfect all toys to be used in the table with chlorine bleach solution. Avoid using sponge toys. They can trap bacteria and are difficult to clean.
- Have all children wash their hands before and after playing in the water table.
- Do not allow children with open sores or wounds to play in the water table.
- Carefully supervise the children to make sure they don't drink the water.
- Discard water after play is over.

HANDWASHING

Most experts agree that the single, most effective practice that prevents the spread of germs is good hand washing by providers, children, and others. Some activities in particular expose children and providers to germs or the opportunity to spread them. You can stop the spread of germs by washing your hands and teaching the children in your care good hand washing practices.

When Hands Should be Washed

Children:

- Upon arrival at the group activities
- Immediately before and after eating.
- After using the toilet or having their diapers changed.
- Before using water tables.
- After playing outside.
- After handling pets, pet cages, or other pet objects.

- Whenever hands are visibly dirty.
- Before going home.

Providers:

- Upon arrival at work.
- Immediately before handling food, preparing bottles, or feeding children.
- After using the toilet, assisting a child in using the toilet, or changing diapers.*
- After contacting a child's body fluids, including wet or soiled diapers, runny noses, spit, vomit, etc.
- After handling pets, pet cages, or other pet objects.
- Whenever hands are visibly dirty or after cleaning up a child, the room, bathroom items, or toys.
- After removing gloves used for any purpose.*
- Before giving or applying medication or ointment to a child or self.
- Before going home.

**If gloves are being used, hands should be washed immediately after gloves are removed, even if hands are not visibly contaminated. Use of gloves alone will not prevent contamination of hands or spread of germs and should not be considered a substitute for hand washing.*

Rubbing hands together under running water is the most important part of washing away infectious germs. Premoistened towelettes or wipes and waterless hand cleaners should not be used as a substitute for washing hands with soap and running water. Towelettes should only be used to remove residue, such as food, off a baby's face or feces from a baby's bottom during diaper changing.

When running water is unavailable, such as during an outing, towelettes may be used as a temporary measure until hands can be washed under running water. A provider may use a towelette to clean hands while diapering a child who cannot be left alone on a changing table that is not within reach of running water. Typically, parents are available in group activities and should be asked to take care of their child's diapering/toileting needs. In those centers that are licensed through DCYF as a day care, all applicable DCYF regulations must be followed.

Water basins should not be used as an alternative to running water. If forced to use a water basin as a temporary measure, clean and disinfect the basin between each use. Outbreaks have been linked with sharing wash water and wash basins.

HOW TO WASH HANDS

Always use warm, running water and a mild, preferably liquid, soap. Antibacterial soaps may be used, but are not required. Premoistened cleansing towelettes do not effectively clean hands and do not take the place of hand washing.

Wet the hands and apply a small amount (dime to quarter size) of liquid soap to hands.

Rub hands together vigorously until a soapy lather appears and continue for at least 15 seconds. Be sure to scrub between fingers, under the fingernails, and around the tops and palms of the hands.

Rinse hands under warm running water. Leave the water running while drying hands.

Dry hands with a clean, disposable (or single use) towel, being careful to avoid touching the faucet handles or towel holder with clean hands.

Turn the faucet off, using the towel as a barrier between your hands and the faucet handles.

Discard the used towel in a trash can lined with a fluid-resistant (plastic) bag. Trash cans with foot-pedal operated lids are preferable.

Consider using hand lotion to prevent chapping of hands. If using lotions, use liquids or tubes that can be squirted so that the hands do not have direct contact with container spout. Direct contact with the spout could contaminate the lotion inside the container.

When assisting a child in hand washing, either hold the child (if an infant) or have the child stand on a safety step at the height at which the child's hands can hang freely under the running water. Assist the child in performing all of the above steps and then wash your own hands.

APPENDIX M

RECOMMENDATIONS REGARDING PHYSICAL FACILITY

It is strongly recommended that all providers consider the following guidelines regarding physical facility:

- Evidence that any private well or water source has been inspected. This evidence is updated every two years.
- Documentation that the center is lead safe. The provider removes any chipping, flaking, or otherwise loose paint or plaster found to contain lead according to current HEALTH requirements.
- If a provider moves to a new site, plans to develop and/or utilize additional space for center-based services or plans to hold group services in another provider's site (e.g., YMCA or a child care facility), the facility is reviewed for Health and Safety by a director or clinical supervisor prior to the start of services.
- All centers have a procedure for regularly scheduled evacuation drills.
- The provider holds practice evacuation drills with all groups of children and all staff at least every other month. The drills are at different times of the group schedule. The provider documents the date, time, and effectiveness of each drill. The provider develops specific procedures to be followed for evacuating children with disabilities and for infants and toddlers who may need additional assistance during an evacuation from the center.
- Emergency Situations: The provider develops specific written contingency plans and procedures to deal with fire, natural disasters, and loss of power, heat, or water.
- The provider facilities have a tobacco, smoke free, and asbestos safe environment.

Indoor space in the center meets the following requirements:

- Floors of rooms used by children are clean, unslippery, smooth, and free from cracks, splinters, and sharp or protruding objects, and other safety hazards.
- Ceilings and walls are maintained in good repair and are clean and free from sharp or protruding objects and other safety hazards.
- All steam and hot water pipes and radiators are protected by permanent screens, guards, insulation, or any other suitable device which prevents children from coming in contact with them.

- All electrical outlets, which are within the reach of children are covered with a safety device when not in use. If the covering is a shock stop, it must be of adequate size to prevent a choking hazard.
- Room temperature in rooms occupied by children are maintained at not less than 65 degrees Fahrenheit at zero degrees temperature outside and at not more than outside temperature when the outside temperature is above 80 degrees.
- There is designated space, separate from children's play or rest areas, for administrative duties and staff or parent conferences.
- The interior of the building is clean and maintained free from rodents and/or insects. Safe and effective means of eliminating insects and /or rodents are provided. A licensed exterminator carries out all extensive extermination.
- The provider provides suitable guards across the insides of any windows that are accessible to children and present a hazard. The provider provides suitable guards across the outside of basement windows abutting outdoor play areas.
- Guards are placed at the top and bottom of stairwells opening into areas used by children. Pressure gates may not be used at the top of stairs.
- Routine, major housekeeping activities such as vacuuming, washing floors, and washing windows are not carried on in any room while the children occupy it.
- The provider provides a barrier, such as a door or gate, which prevents children's access to the kitchen while unsupervised.
- The kitchen is maintained in a sanitary condition, and garbage receptacles used in the kitchen are emptied and cleaned daily.
- The provider maintains eating areas that are sufficiently large to fit tables and seats for children eating in an uncrowded manner and are clean, well lit, and ventilated.

Equipment:

- The provider uses only equipment, materials, furnishings, toys, and games that are appropriate to the needs and developmental level of the children. They are sound, safely constructed, flame retardant, easily cleaned, and free from lead paint, protruding nails, rust, and other hazards, which may be dangerous to children.
- The provider keeps all equipment, materials, furnishings, toys, and games clean and in safe workable condition. Equipment is sturdy, stable, and nontippable.

- Some materials and equipment are visible and readily accessible to the children in care and are arranged so that child may select, remove, and replace the materials either independently or with minimum assistance.
- The provider provides equipment which reflects the racial and ethnic composition of the children enrolled.

Toilets and Washbasins:

- The provider maintains one toilet and washbasin for every 20 children in one or more well ventilated bathrooms.
- When adult toilets and washbasins are used, the provider provides non-tippable stairs to permit access by those children who are able to use them.
- In addition to toilets, portable "potty chairs" may be used in the bathroom or separate room for children unable to use toilets.
- If cloth diapers are used, a flush sink or toilet for rising diapers and a hand washing facility is provided convenient to the diaper changing area.
- Special handrails or other aids are provided if required by special needs children.
- The provider provides both hot and cold running water in wash basins with scald resistant faucets and for water used by children. There is a temperature control to maintain a hot water temperature at no more than one hundred twenty (120) degrees Fahrenheit.